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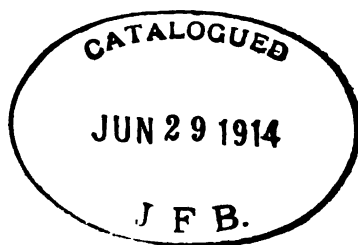
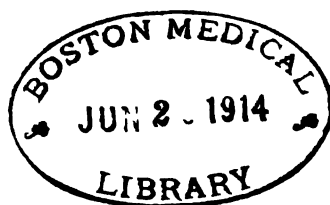
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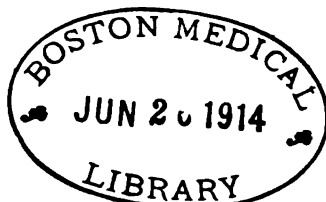
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ELEVATION OF TEMPERATURE IN THE PUERPERIUM.

BY

L. L. DANFORTH, M. D.

THIS subject, fever in puerpera, is well worthy of the attention of practical obstetricians, because it is one which they are frequently called upon to treat, and the origin of it is sometimes most difficult to determine. In fact I know of no class of cases in the whole range of medicine which cause the attendant such uneasiness as that of puerperal fever—using the term in its broad sense.

Who has not had such an experience as the following? The patient passes through the labor without unusual difficulty. All goes well until the second or third day—or even as late as the fourth or fifth day—when a sudden rise in temperature occurs, preceded or not, as the case may be, by a chill, or chilly sensations. The fever reaches a high point and then recedes, to be followed by a more or less

persistent elevation of temperature which may continue for days. One's first impulse is to suspect some fault in the technique of delivery—infection is feared—and silently one suffers the anxiety which comes only with the knowledge which the nature of this dread complication can give. An examination of the pelvic organs is made, and nothing definite is found; nothing which can actually be considered as an adequate cause for the persistent fever. It is impossible to locate the focus of trouble either within or without the uterus. One asks himself, "Is this septic endometritis or peri-uterine inflammation? Or is it some intercurrent malady not dependent upon parturition?" It may be impossible to answer the question satisfactorily, and the most learned physician on puerperal septicæmia may be non-plussed. So thoroughly are we imbued with the idea of the septic origin of most cases of fever in puerpera that we at once begin the systematic cleansing of the genital tract; we douche the vagina and the uterus; the latter is finally curetted; internal remedies are given, and the fever persists. We are in the deep sea of uncertainty and doubt. There is a cause somewhere and we must find it. Such an experience as this has not infrequently been mine, and I have often been called upon by others in the same predicament to give them the benefit of such advice as I could command.

To attempt to throw some light upon these cases of fever of obscure origin in the puerperium is the object of this paper.

In the first place it may be well to state that we shall consider actual fever to be all elevations of temperature above 78° C. (100.4° F.) This is an arbitrary figure and may be too high, but it allows for those cases in which the temperature rises within twenty-four hours after delivery as a result of the reaction from the severe effort of the labor. Leopold of Dresden, and Neumann of Mannheim regard every temperature above 100.4° F. as fever. Van Szabo

of Prague counts 100.75° F. as the fever limit. Boxall of London classifies as fever all cases in which even a single rise above 100° F. occurs. Lambert believes that the puerperal state is incapable in any of its normal relations of causing pyrexia, and he is strongly of the opinion that temperature above 99° and 100° F. often indicate a beginning pathological process—septic in origin—which is responsible for many of the pelvic conditions subsequently treated by the gynecologist.

I shall confine my remarks to an enumeration of those conditions which may give rise to pyrexia during the puerperium—and make some comments on the differential diagnosis of each.

I shall dwell first upon those cases in which fever is due to infection of the puerperal wounds.

The diagnosis of septic infection is sometimes quite easy, and again it is shrouded in obscurity. The cases which are the most virulent are apt to have the fewest local symptoms upon which to base a diagnosis. In all cases of doubt it is advisable to make a visual inspection of the vulva, vagina, and cervix. Small white patches on the raw surfaces may mark the site of infection and render the diagnosis clear.

When the infection is through the endometrium or by way of the tubes, the fever may persist for a week with little pain or tenderness before we can find local evidence of its cause. This may be discovered finally as an induration high in the upper portion of the broad ligament, or even in the iliac region. Septic infection may be so intense as to produce a very high fever—and death may occur in two or three days from cardiac paralysis due to the virulence of the poison. The disease is so rapid in its course and termination, that no time is given for the production of definite pathological lesions. Fortunately such cases are extremely rare. The cause of the fever when due to septic infection and accompanied by usual local and general signs is easily diagnosed. The well-marked pelvic and abdominal

symptoms—such as tenderness of the uterus or along the line of the tubes, ovaries, and connective tissue within the folds of the broad ligaments, abdominal tenderness, foul lochia, persistent fever, accelerated pulse, and the general evidence of severe systemic disturbance, makes the cause of the temperature rise only too evident.

It cannot be too often reiterated that most of these symptoms may be absent and yet septic infection exist. When infection takes place by way of the endometrium, as in gonorrheal diseases of genital tract, the attack may be so mild as to cause no tenderness of the uterus, no alteration of the lochia. The fever is of moderate severity and may come on soon after delivery, with quickening of the pulse; other than these symptoms there is nothing to point to the nature of the attack. Krönig gives an analysis of nine cases of *post-partum* infection by the gonococcus alone. In four high fever occurred without other special symptoms; all recovered without special treatment. The pyogenic cocci may coexist with the gonococcus, and cause the infection during delivery.*

Sometimes a tender uterus and foul smelling lochia will coexist with constipation and engorgement of the breasts, thus making the accompanying fever of doubtful origin until the discharge of portions of foul-smelling secundines indicates the nature of the disorder.

Fever coming on at any time up to the sixth day, accompanied by headache, pain in back and limbs, and reaching 102° to 103°, with acceleration of the pulse, may be due to mild infection through the endometrium as shown by tenderness of the uterus and parametria. The local conditions would render the diagnosis clear, if there were any doubt before their appearance. Such a fever will arise as a result of neglect of the ordinary antiseptic precautions, of the external or internal genitals. Physicians are too apt to overlook these cases of slight febrile rise which they

* *Centralblatt für Gynakologie*, 1893, No. 8.

attribute to the incoming of the milk or some other transient cause.

It is unnecessary before a body of practical obstetricians to enumerate the symptoms, local and general, which characterize well-pronounced septic infection. It is my intention to point out the fact that fever may exist and, though due to sepsis, the ordinary local and general symptoms may be absent or be so mild as to escape detection, especially by one not skilled in the diagnosis of the local conditions which accompany this state. The bimanual method of examination will reveal evidences of disease in the fallopian tubes, broad ligaments, lymphatics, or pelvic connective tissue, whereas the method by the examining finger in the vagina without the aid of the external hand will show nothing that is distinctive. One point is worthy of note in regard to the time of the appearance of fever in septic cases, and that is, the fever may not make its appearance until as late as the fifth or sixth day, and even may not come on until late as the tenth or eleventh day.

It is generally believed that septic fever usually makes its appearance on the second or third day, and in the majority of cases it does appear about that time. But there are many exceptions to this rule; when the local condition is bad the septic infection is correspondingly intense.

Fever of septic origin is gradual in its onset and generally remittent in character; it may be scarcely above 100.5° for one or two days before any high febrile action is noticed. From this point it may go on progressively higher, reaching 104° or 105° on the sixth or seventh day of the disease. On the other hand it may be marked by distinct remissions and then cease suddenly on the adoption of appropriate treatment. A valuable diagnostic indication of the septic origin of the fever is the character and frequency of the pulse. It is often out of all proportion to the height of the temperature, while its force is diminished and the tension lowered. An irregular pulse is a bad

prognostic indication in fever of septic origin. The lochia is most decidedly altered in cases where retained products of placenta or membranes are left in the cavity of the uterus. In most cases it shows evidences of change before there is any constitutional disturbance; it becomes bloody, and changes odor rapidly. On the other hand there may be no such changes at any time, even in the most advanced cases.

As an indication of the nature of the fever the progress of involution will throw light upon the case when other evidence is wanting. Retarded involution is the rule, although the removal of the cause by active treatment addressed to the interior of the uterus will often re-establish the process, and it will then go on in the ordinary way. Pain and tenderness of the uterus and parametria are the most constant local symptoms. These symptoms are increased in direct proportion as the peritoneum becomes involved. Cases in which the fever is most insidious in its onset, and most persistent in its course, are those in which the lymphatics and pelvic veins are involved. A septic plebitis may easily escape detection until the saphenous or femoral veins become involved. The nature of the case is then made clear, by the external evidences of inflammation in these vessels. Chills and sudden elevation of the temperature to a high point with as sudden a fall followed by profuse sweats, mark the development of pus formation somewhere in the pelvic tissues. It was not the intention to dwell upon the signs of septic fever, but some points in the diagnosis of this disease which are obscure and unusual have been dwelt upon in order to make the comparison between this and other causes of fever more apparent.

Fever in puerpera is often due to complicating diseases. Among the most common of these may be mentioned malaria.

It is well known that a patient affected with paludism will tolerate for months the presence of the plasmodium of

Laveran without a suspicion of its existence, until such a time as the resistance of the system is reduced below the normal standard, and then it suddenly bursts forth in all its fury. The puerperal state offers an excellent opportunity for the manifestation of the malarial miasm. It is the experience of the writer that the period of pregnancy affords a special immunity from this poison, while the puerperal state prevents conditions especially adapted to its activity.

One should be very cautious, however, in attributing a chill and fever in a puerpera to this cause. It is sometimes impossible to make a diagnosis as to the true cause of the fever, until a paroxysm has been watched to its termination. A diagnosis of malarial fever should never be made until a careful examination has excluded all other possible causes, among which the most probable will be septic infection.

The chief distinguishing feature of malarial fever is the high temperature, which quickly reaches its maximum of 104° or 105° , immediately following the initial chill, and its sudden decline within twelve or twenty-four hours to near the normal point. There may be a repetition of the attack within the following twenty-four hours, or the fever may be remittent and decline gradually to the normal point under appropriate treatment. Cases of this character are often very perplexing and troublesome. One can exclude sepsis only by the most careful examination of the pelvic organs, and even when this has been done, there is sometimes an element of uncertainty in the case, as the general systemic disturbance will give rise to slight congestion and tenderness of the uterus, which simulates closely the beginning of septic metritis. The longer the fever continues the greater the uncertainty, and experienced observers are occasionally greatly perplexed. An interesting case, which will be as appropriate here as anywhere, because it exemplifies very forcibly the difficulties which are incident to the diagnosis of some cases of fever in puerpera, will now

be narrated. The patient was a colored woman aged twenty-one, unmarried; entered the hospital connected with the New York Medical College for Women, New York City, on March 25. I am indebted to Dr. Mary Brewer, then assistant house physician, for this history. I saw the patient several times in consultation and was present at the autopsy. Dr. Brewer says: "Patient seemed to be in fair general health; mentally, was nervous and apprehensive. Was troubled much with wandering pains for some two days *before* labor set in, which it did early in the morning of the 25th of March; the child was born before 7 o'clock P. M. of that date. The labor was severe, and the patient suffered much with nervous excitement and fear; even to slight delirium.

"Within twenty-four hours after delivery, the temperature had risen to 104° , continued high for forty-eight hours; then sank to $99\frac{1}{4}^{\circ}$, but quickly rose again to 103° . From the third day forward, the temperature was never below 102° , and but little of the time below 103° and 104° . Pulse ran high, for the most part 120-160; respiration 30-70. From first to last there was a singular absence of pain; no headache, no backache, no abdominal pain to speak of. There was, in the early days, slight uterine tenderness, but this passed away so completely that only deepest pressure found any tender spot, this being in the left broad ligament. Upon vaginal examination, the cervix was found small, firm os, well closed, no tenderness, no odor. Lochia and milk normal and plentiful until toward the last. Examination of urine showed albumin and casts; yet the excretion was abundant from first to last, and was voided without difficulty. For the last week or so there were heavy sweats of head and shoulders, and a clamminess of skin all over. No special bowel symptoms; no tympanites; no large accumulation of gas, and what there was, was readily and freely passed. No marked restlessness. Beyond the fever itself, there were no marked symptoms, excepting absolute sleepless-

ness; the large eyes remained so widely and persistently open as to be a noticeable feature of the case. She died in the early hours of the thirteenth day after the delivery, with a temperature of 107° . The autopsy showed an acute nephritis engrafted upon a chronic condition, but neither the acute nor the chronic disease was sufficient to cause the fever or death. No other organic disease was discovered, excepting an hypostatic pneumonia of the lower lobe of left lung; all other organs were in a healthy condition. The uterus, however, was found to contain a piece of placenta, as large 'as the upper joint of one's thumb,'—but *not* in bad condition; and in the left broad ligament was some congestion and swelling, corresponding to the tender spot in life."

This case was most perplexing. The patient was most carefully examined and absolutely nothing could be found upon which to base a positive diagnosis, and with the added light thrown upon it by an autopsy, during which every organ was carefully inspected, I still have no positive opinion concerning its pathology. The involution of the uterus was normal, there was no foci of pus formation anywhere, no inflammatory exudations; nothing except the small fragment of placenta referred to in the report. The interior of the uterus was clean and there had been no foul lochia. The kidneys were diseased, but the trouble here began long before the date of confinement and had nothing to do with the acute sickness, nor with the death. The congestion of the lung was dependent upon the general disease and not an original cause.

There are two possible explanations: one that the disease was malarial in character, and the other that it was intensely septic from the beginning. Cases as strange and obscure as this have been reported in medical journals from time to time, and divers causes have been assigned for the elevation of temperature in the different cases. The most experienced diagnosticians have been baffled in their efforts to make a satisfactory diagnosis in such cases.

While I am not positive, I am of the opinion that this was a case of what is termed *acutest septicæmia*—which kills by the intensity of the poison by its effects directly upon the blood and nervous system. I am inclined to this belief because of the rapidity with which the fever developed and its high grade throughout. Only once did it drop to 99½°, and then for a short time only. The character and rapidity of the pulse and respirations were also strongly indicative of septicæmia. The high nervous excitement also pointed to this cause. I have placed the case under the head of "Fever Due to Complicating Disease in the Puerperium," because of its doubtful nature and yet I am pretty well satisfied that it should be put down as distinctly septic in origin.

In city practice we not infrequently meet with cases of fever of the remittent type which resemble true septicæmia, but in which the essential local signs are lacking, nor are the symptoms those which are considered characteristic of the fevers induced by malarial miasm. The marked periodicity of the true malarial fever is absent; the fever assumes a remittent type; the stomach is usually greatly disturbed, nausea and vomiting being common symptoms; the remissions of the fever are attended by profuse sweats. The lacteal secretion is not diminished except as it may gradually subside, owing to the weakened and anæmic condition of the patient. Such fevers will sometimes run a protracted course, and baffle all attempts to break them. Fevers of this variety complicating the puerperium are sometimes due to sewer gas poison. The miasm may be taken into the system by means of the inspired air of rooms rendered impure by emanations from defective sewer pipes, the infection taking place gradually and long before the period of confinement. On the other hand, the genital tract may be directly infected. Noeggerath found, in the discharges from the uterus of a puerperal patient ill with a fever resembling both septicæmia and true malarial

fever, microbes identical with those found in scrapings from long-used water pipes opening into the room occupied by the patient. The possibility of such a source of infection should not be forgotten, and Noeggerath's discovery may throw light upon many cases of *post-partum* elevation of temperature in which the element of sepsis can be excluded.

It should not be forgotten that the puerperal woman is as liable as any other to acute inflammatory diseases. The writer can recall two cases observed during the past year where the fever was supposed to be septic, but which proved to be in one due to acute lobar pneumonia (non-septic), and the other to an empyema. Both patients were seen in consultation—one was a case of placenta prævia which the writer delivered at the eighth month. After the delivery the case was left in the hands of the attending physician. Several days afterward the writer was recalled to examine the patient, as she was supposed to be septic. A careful physical examination revealed a croupous pneumonia of the lower lobe of the left lung. This affection had not been suspected. The other case was an instrumental delivery after prolonged and ineffectual labor. A chill on the sixth day, followed in rapid succession by signs of acute pleurisy, developing into an empyema. Neither condition (pleurisy and puerperal state) seemed to have any influence on the course of the other.

Fever Due to Changes in the Breasts.—Fever due to this cause is well known. "Milk-fever" was formerly employed to include nearly all moderate elevations of temperature occurring during the first week of the puerperium. As our knowledge of the causes of "puerperal fever" has widened, we are compelled to limit the term to those slight febrile movements that may be excited by the primary engorgement of the breast occurring at the time when this secretion is first established. The elevation of temperature is low in all such cases and does not exceed 101°. A rise

above that point indicates either a more formidable inflammatory process in the breasts, superficial or deep, or some other distinct affection.

Constipation.—The explanation of fever due to this cause is so clearly given by Drs. Lambert and Painter in the medical report of the Society of the Lying-in Hospital of the City of New York (1893), I cannot do better than repeat their conclusions. As regards ætiology, these authors say :

“The cause of the rise of temperature is not the simple fact of constipation itself, but there is undoubtedly an absorption of pyogenic toxalbumins or allied bodies which would be removed by the emunctories of the system if the bowels were moving freely and regularly. Although many of the older writers have recognized this condition as a cause of fever, we have not found many references to it in the writings of recent authors. Schroeder (37) mentions it in his text-book (p. 285), and we quote the following from the pen of Roswell Park of Buffalo : “The condition of entero-sepsis, fecal toxæmia, stercoral intoxication, or whatever it may be called, is certainly one which every practitioner has to fear and against which he should assiduously guard. It is not generally enough recognized and combated.

“In these cases of fever from constipation there are no local signs except, perhaps, a varying amount of tenderness over the sigmoid flexure of the colon, but only appreciable where the distention of the gut is extreme.

“The general symptoms are few. The febrile movement generally begins suddenly and rapidly reaches a maximum, which may be quite high. In other cases, the temperature runs a lower but a longer course. If the temperature be not treated, it continues progressively without a characteristic curve until relieved by a spontaneous movement of the bowels. *Pulse* : The quality of the radial pulse is strong and full and its rapidity is not commensurate with

the height of the fever. In a few of these cases only has a pulse of 120 been recorded, even when the thermometer was registering at 104°. *Headache* is a prominent symptom and is an intense general or frontal pain. Such a headache is present in cases with a low degree of fever, as often as in those with a sudden, sharp, febrile action. *Chills* are present in a small minority of those cases in which the temperature rises suddenly. *Sweating* is quite common, especially accompanying the prolonged rises of temperature. A feeling of general malaise is more or less pronounced while the constipation lasts."

From the analysis of cases of fever from this cause reported by Dr. Lambert, we observe that in by far the larger proportion the onset of fever came in the first three days *post-partum*, though quite a number had fever on the fifth or sixth day, and a few others from that time on to the twenty-first day. In the majority of instances the fever does not rise above 101.5°, but it may rise as high as 102°, 103°, or 104.5°. Fever due to constipation is of short duration, lasting from one to three days, and is relieved by the free use of saline cathartics.

Fever Due to Recurrence of Pre-existing Inflammation.—

As a result of the traumatism incident to delivery a pre-existing latent pelvic inflammation may be lighted up, and speedily passes on to an acute process. This may occur independently of fresh septic infection received at the time of labor. The only evidence of such an occurrence is the presence of fever, with some tenderness at a point of induration, which may be felt somewhere in the pelvic connective tissue. Resolution of such an inflamed area may take place, or a pelvic abscess may develop after weeks of fever of moderate intensity. A knowledge of the previous history of the patient would aid in establishing the nature of such an attack.

A recent case seen in consultation with Dr. G. W. Roberts of New York City is a notable example of this

variety of pelvic inflammation. The patient had a history of pelvic cellulitis and peritonitis following a previous confinement. The last labor was conducted by Dr. Roberts in the most careful manner, and every aseptic precaution observed. On the third day after confinement the patient had a chill, followed by high fever, which continued with moderate remissions for two weeks or more. Though the lochia was unaltered and the lacteal secretion normal, the uterus was carefully curetted on the fifth day. But the progress of the fever was unabated. A mass as large as one's fist developed in the right broad ligament. The peritoneum and the uterus became more or less involved, with the usual pain of a localized peritonitis. An abscess was greatly feared, but under appropriate treatment, resolution set in, though not till a similar though smaller mass developed on the left side. The patient recovered completely, without abscess formation, under homeopathic remedies—and the exudation had nearly disappeared when the writer last heard of the case.

Inflammatory exudations with small foci of pus, in broad ligaments or in parts contiguous thereto, prove most perplexing when they become acutely inflamed under the influence of pregnancy or labor. Persistent fever may be almost the only evidence that anything is wrong. Local pain or deep palpation will usually be discovered.

Fever Due to Emotional Causes.—The first days of the puerperal period are "critical days" in more senses than one, as has already been shown. It is then that the nervous system is in its most impressionable state, and at the same time many patients have a surprising lack of control over the mental processes. Influences which at other times would be resisted with impunity then become colossal in their magnitude, and proportionately disturbing in their effects. Under these circumstances an elevation of temperature will sometimes suddenly appear—and unless the cause is suspected and verified by careful questioning

the diagnosis may prove difficult. Fortunately emotional fevers are of short duration; they flash up quickly and as quickly subside. Dr. Hirst of Philadelphia gives the chart of a case ("American System of Obstet.," p. 493, vol. ii.) in which the temperature suddenly rose to 105° from dread of an operation, and as suddenly receded.

The writer can recall instances where fever reaching 102° or 103° has developed in the most mysterious manner, when all appeared to be going well with the patient. Investigation of every possible source of fever proved fruitless. On the subsidence of the fever the truth has appeared; some grievance, fancied or real, disturbed the patient's mind, as she dwelt upon it she became filled with mixed emotions of anger and disappointment; the pulse became quickened, the skin hot and dry, the temperature rose, appetite and digestion diminished, and the patient had the appearance of being really very ill. But so volatile are such emotions and so transient their effects, convalescence is soon established, though no little anxiety is felt during the continuance of the attack.

Effects of Cold.—A case recently seen exemplifies the nature of febricula due to cold, chilling the surface of the body.

A multipara, after an easy labor, did well until the fifth day. The milk came abundantly and normally. The nurse was obliged to leave the patient for one night; during her absence the mother, while perspiring, sat up in bed to nurse the infant. The next morning, to my astonishment, the mother was found to be very ill: temperature 104° , pulse full and bounding; headache; flushed face; aching and soreness of every muscle in the body, and of the eyeballs. The uterus was tender to touch, extremely so, and there was a free discharge of blood from the uterus, which previous to the sudden illness had nearly ceased. A careful examination of every organ gave negative results, though the tenderness of the uterus, and the flow of blood

were suspicious symptoms. In consideration of the exposure, and the nature of most of the symptoms, sepsis and all other serious conditions were excluded, *bryonia* and afterward *belladonna* removed in two or three days all trace of the annoying relapse.

But I have already been too prolonged. These are not all the causes of fever in puerpera, but enough have been mentioned to show that it is often difficult to determine the true cause; that septic infection is often difficult to diagnosticate, and that other and simple affections simulate it closely.

In a given case of fever in puerpera of doubtful origin, the only safety lies in interrogating every possible source of disease, leaving no methods of diagnosis untried, and no organs neglected in the search for the true cause of the malady.

ECLAMPSIA. (PUERPERAL.)

BY

WILLARD A. PAUL, M. D.

I N regard to my eclampsia cases will say, I was one year at Hahnemann Hospital, as house surgeon, and practiced in Rock Island ten years, with a fair business, and did not see a single case until April, 1891, and during the months of April, May, June, and July, I had five cases, and have not seen one since. While I was from home attending my second case I was called to another, which, could I have attended, would have made my No. six. This case resulted fatally.

Case number one came on at seventh month: Perfectly healthy young woman, second pregnancy, very dark complexion and was entirely normal up to the sixth month. The first pregnancy was normal, and had a normal delivery at full time with no untoward symptoms. In the second pregnancy, at the sixth month had some very slight symptoms of general dropsy, very little about the eyes, feet and perhaps, abdomen, hardly noticeable. Urine, one week before the attack, showed no albumin, or other abnormalities. Saw the patient four hours before the attack, she was about the house and attending to her little daughter, for whom I was really called, but after seeing the child, as the mother had not been quite well and considering her condition, I examined her and prescribed. Found her as above, with some slight malaise. At nine o'clock that evening, without warning, she had a very hard convulsion. I arrived at her bedside in twenty minutes, and she was in the second convulsion, which, being my first sight of such a condition, was, I must confess, very unnerving; but thanks to the superior instruction I had received ten years before at the hands of Professor Leavitt, and to a con-

stant study and reading of the subject of obstetrics in all its phases, I knew just what to do and at once set about it. She could not, for five minutes or more, take medicine per ora, hence I at once injected into the rectum one ounce bromide pot., dissolved in water, gave an assistant chloroform to administer as soon as her breathing was fully established, and, before she had hardly ceased the convulsive motions, I began to dilate the os preparatory to delivery.

I found the os firm and unyielding, and so close I could hardly pass a sound had I tried. I was enabled, after five minutes' trial, to get the uterine dilator inserted and by vigorous use of the same, got my index finger through the os shortly after the third convulsion, which followed the second in about twenty minutes. Between the second and third convulsions I administered two doses of verat. vir., five drops 2d x, per ora. The third convulsion was so very severe I feared death in the next, unless I could empty the uterus, and with such a firm os and no contractions, I knew I could not accomplish this, so we pushed the chloroform as fast as I dared, as soon as breathing was established, and, hoping to secure some contraction, I injected into the rectum one-half ounce of fluid extract of ergot, Squibbs'. The fourth convulsion came on twenty minutes after the third, and was very severe, but much less so than the third; and at about the same time I was rewarded with some slight contraction, and I had gotten two fingers in the os, and was making rapid headway at dilatation. I continued my internal remedies, when she could take them, and if she could not take them, as was the case four or five times during the night, I gave them hypodermatically. After the fifth spasm, which was still less severe and the interval longer, I gave another injection of ergot per rectum. I continued the chloroform all the while. At about the time of the fifth convulsion, a doctor, for whom I asked a neighbor to telephone for immediately on my arrival, arrived. He very quickly took in the situation,

advised with me, and took charge of the chloroform and remedies for a time while I worked at the now yielding os. When my hands were nearly paralyzed, the doctor took my place, and at one o'clock he thought it possible to apply the forceps, which I did, using Hale's small forceps, as the head by this time was lying low, and it seemed better to use the smaller, instead of Elliot's, which I always do use. I succeeded in applying them, and quickly locked them just inside of the soft parts. She had just gotten through the eighth convulsion, the last three not so long or severe as the preceding ones, and I made traction immediately. There were good expulsive pains now, and in less than fifteen minutes we delivered a large seven-months male child. There had been no movement of the child during the night, or for some time before, and every indication was that the child had been dead some hours.

The patient had five convulsions after this, one or two being quite severe, the last one about 7 A. M., after which she had a very easy sleep of three hours. When she awoke she was conscious and in remarkably good condition considering all she had been through in the last thirteen hours. She made a rapid and almost normal convalescence. There were no lacerations and all the organs apparently resumed their normal state. The patient was troubled for a year or eighteen months with spells of great malaise and some melancholia, but this all passed off in time and she is now perfectly well. I am somewhat apprehensive of another pregnancy, but think if such an event be postponed a few years, there will be no trouble. From the various cases I have read of and know about, I consider this one to have been a typical case of eclampsia, and one in its most severe forms. We might have had equally as happy results under a different line of treatment, but I am naturally somewhat enthusiastic over this, my first case.

If I were to make any suggestions to others who have

not had any of these cases, I should advise them to be thoroughly posted on the care and treatment, to be always ready, and go prepared for such emergencies and get to work at once on the case when called. I think I owe my success in this case to the fact that I had with me what I needed; that I went to work promptly to relieve the condition so far as drugs could relieve; and that I lost no time in emptying the uterus. In prescribing, I gave the indicated remedy as I could determine; having before me the pathological condition, knowing her past history and system, I affiliated as nearly as I could the remedy. I used bell., ign., ver. vir., nux mos., etc. I tried to control the conditions as much as possible with drugs, viz., chloroform and bromide, and used the ergot to aid the delivery. I could hardly have accomplished the task, anyway not so soon, without the aid of the other doctor, as I was nearly worn out when he arrived, hence would advise summoning aid at the start.

I had, as before stated, four other cases during the next three months, none quite as severe a type, but generally much the same: One came on during full time delivery, had five spasms, three before and two after; good recovery. A third had a convulsion just after delivery, before the placenta was removed. She had eight convulsions in all, four before I had fully emptied the uterine cavity, which had to be done by tearing the placenta into pieces. The fourth case was almost a duplicate of the first, only not as severe, and I saved the child. The fifth was in consultation with my brother, Dr. F. D. Paul, at Cambridge, Ill. Patient confined three days before by a village doctor, who left her on completing, as he thought, the delivery of the afterbirth. In twenty-four hours she had a convulsion, and they sent for my brother, who got there, four miles in the country, when the baby was almost two days old. He immediately removed a large piece of placenta, and after prescribing ver. vir. and passiflora, a few more spasms came

on, and he wired me to see the case with him, which I did, getting there the third day. We removed more of the afterbirth, all of it this time, and put her on bell. and china sulph. She had two more spasms and made a good recovery.

Whether either case could have been averted by careful early treatment, I do not know. My first and worst case was under treatment and had been carefully watched, urine tested, etc. I think the fourth case, the one with the rigid os, could have been averted by bringing on labor two weeks earlier which I was tempted to do, as I had feared trouble, and had noted some slight trace of albumin in urine, with some bloating about feet and eyes. I think we cannot keep too careful watch of all our obstetrical cases from conception to delivery, and many times by prompt action, prevent serious trouble, by remedies, expedients, diet, or by even hastening delivery.

Veratrum vir., china sulph., cuprum, and gels. are the remedies I saw most good from. All my cases were multiparæ but one; three were undoubtedly of uremic origin, only one stillbirth, the first case at seven months. One case had been in labor fifteen hours, rigid os. First spasm came on just as the os became patulous, and before the second spasm, put on the forceps, and was on the point of delivering the child when the third spasm came on, forcing the head through and rupturing the softs parts $1\frac{1}{2}$ inch into the rectum; very large, strong child; two spasms after the delivery.

Always carry full equipment for emergency cases. To this fact I owe at least the life of my first patient.

PREMATURE BIRTH, DUE TO SHORTNESS OF
THE CORD, CAUSING DETACHMENT OF A
PORTION OF THE PLACENTA.

BY

B. G. CLARK, M. D.

MRS. P., age thirty, married about one year, menses regular, somewhat painful owing to a retroversion of uterus. Menses, June 24, 1893, after which conception took place, slight nausea first month, then began to have pain in back. By August 10 the pain in back and distress was worse and I was sent for, but was out of town, and the doctor attending to my work responded and prescribed for her such remedies as seemed indicated, but did not afford relief. The doctor was young, and had not suggested any examination, and the family feeling her trouble due to some local cause on account of her former trouble (retroversion), sent for the doctor who had treated her for that displacement, a year or more before, with much benefit.

The doctor called, found the uterus retroverted, and after replacing it put in tampons of cotton to keep it in place. This physician was about going out of town, and asked a neighboring physician to continue the same line of treatment, which was done for about two weeks. The manipulation necessary to replace the uterus was not painful. After the first of October she began to feel so much better that she was about her accustomed duties, without the need of a physician until the middle of January, 1894, when she began to experience some pain on the right of fundus of the uterus, mostly while lying down. This continued, and by the middle of February she was obliged to to be bolstered up in bed in order to sleep; she was still more relieved by drawing her knees up. This pain was

aggravated at each violent movement of the fetus; slight movements did not cause much if any pain, and pain was not severe when she was standing, sitting, or walking; more lying on back and still more on left side. Remedies afforded very little relief. Examination about this time revealed nothing abnormal by palpation; there was a slight tenderness over the right portion of the fundus uteri; heart sounds of fetus were feebly heard on the left and below the umbilicus of mother, indicating the "first position" of fetus. Confinement was expected April 1, but on March 1, after a restless night and a few minutes after a more severe pain in the painful spot than usual, the "waters broke" and with the discharge of liquor amnii quite some blood must have escaped, judging from the appearance of the bedclothes when I arrived an hour later. I found the patient very comfortable, no pain, could lie down in any position or sit up without pain for the first time in two months; examination showed the os dilated to about the size of quarter of a dollar with the presenting part firmly held in the cervix. I was unable to determine the position, but thought it a "breech." I remained nearly an hour, and as everything was quiet I left to attend to some other calls; returned at noon, but as no change had taken place I again left; was telephoned for at 4 P. M., arrived at 4.15; found regular labor pains were on and fetus advancing a little. At 5 P. M. the advancing portion of fetus was nearly to the pelvic outlet, but the parts were rigid and no advance was being made. By changing the position of the presenting part a little fresh blood would come out that seemed to me to be more than normal; patient's pulse was good and regular. I applied the forceps, gave a little chloroform, remarked to nurse that I thought I had hold of a breech, but was very uncertain what it was. I delivered the fetus with very little traction, but with it came a torrent of blood and patient collapsed, pulseless. Dropping fetus I grasped the uterus

through the abdominal walls and quickly inserted my hand into the uterus, scraped off the remaining placenta, and very carefully removed my hand as the patient revived and contraction commenced. Pulse could soon be felt, and in a few minutes the patient was quite herself. I then turned my attention to the "product of conception." I found that my forceps had grasped the head; the occipital bone was fully developed, the parietal only partially; same can be said of temporal and frontal bones, so that the vertex presented in one large soft mass which I thought was the buttocks, and just back of it a bone, which seemed to be the coccx, was found to be the edge of the occipital bone. The ears were far apart and on a level with the mouth. Lower lip, tongue, and lower jaw seemed natural; upper lip and nose was split open and laid upon the face. Eyes were far apart and diverging, or looking from side of head rather than from the front. Right arm developed from shoulder seemed perfect; left arm and hand developed from skin just above the nipple and only $2\frac{1}{2}$ inches long. The stomach, liver, and intestines were developed entirely outside of the body of the fetus from a fistulous opening, the left side on a line of axilla, near border of last rib. The left leg was fully and perfectly developed, right leg was perfect in shape except the ankle, which was not movable, and foot was turned inward. The umbilical cord was small and only six inches in length; a part of the placenta was still attached to the cord.

The cause of the premature birth I believe was due first to the short cord, which made so much traction during a violent movement of the fetus that a portion of the placenta was detached and the membranes were ruptured at the same time; from that time on there was concealed hemorrhage, but owing to the rupture of the membranes and firm contraction of uterus around the fetus the hemorrhage was partially stopped by compression.

The cause of the malformation of the fetus I leave for

your consideration, suggesting that perhaps the manipulation of the uterus during the early development of the fetus had much to do with it, as forming a distinct impression upon the mother, and I would suggest the use of a carefully fitted pessary for such cases, to be worn about the fifth month, when it can be removed without danger of retroversion, as the uterus is by that time well above the sacrum.

In looking over the literature upon the subject, I did not find any cases recorded of premature birth due to "separation of a portion of the placenta" on account of a chord. In Guernsey's "Obstetrics," p. 249, he says "shortness of the cord may occur as a complication and delay labor very much. The strongest symptom is the continued retraction of the child, time after time, after the cessation of each pain," and adds, "there is danger of a rupture of the cord or separation of the placenta, exposing the child and mother to a severe loss of blood before the child is sufficiently far expelled to expose the cord; in this event the treatment is still the same: apply the instruments necessary for hastening the expulsion of the child." In the HOMEOPATHIC JOURNAL OF OBSTETRICS for September, 1894, p. 413, Dr. Milton J. Bliem of San Antonio, Tex., writes under the head of "Dystocia from Shortened Cord," and recounts a case he attended at full term with a cord twelve inches long, which was around the child's neck. Child was dead on delivery and a part of the placenta was separated at the time. In the same journal, p. 539, Dr. E. M. Hale of Chicago, Ill., reports a similar case with cord nine inches. In the "Cyclopaedia of Obstetries and Gynecology," by Dr. A. Carpentiere, translated under the supervision of, and with notes and additions by Dr. Egbert H. Granden, vol. i, p. 222, he says "shortness of the cord may be absolute or natural, or relative from twists or knots. The shortest recorded cases are those of Scalfer, which were hardly one-half inch long; Malgangne, 2.7 inches; Meissner Roale,

4.5; Depaul, 4.8; while Mason, Goode, Steele, Mmes. Danthes and Trouret have recorded cases in which the cord was entirely wanting.

"A cord is short when there is not enough of it to permit the expulsion of the fetus without detachment of placenta, In some cases absolute shortness of the cord has been found coincident with certain deformities, and Carus and Froebel claim that they bear the relation of cause and effect.

"Symptoms.—(a) Absolute shortness. During pregnancy considerable pain is felt at the fundus uteri, and the fetal movements, though very limited, cause great distress. During labor, dilatation is very slow in spite of frequent and severe pains. At the intervals of the pains the uterine walls retain a certain hardness. The umbilical souffle may be heard, and finally, in some cases, there is a sense of resistance, followed by tearing with a snap, indicating rupture of the cord. These signs, however, are rather hypothetical. (b) Accidental shortness. Though still uncertain, the symptoms are more important. During pregnancy, according to Devillurs, pains occurring weeks or days before delivery felt in the region of the kidneys; premature rupture of the membranes, though we think this the exception rather than the rule; diminished extent of motion or very disordered or brusque movements of the fetus. Elevation of the fundus uteri at an advanced period of uterine dilatation, and lastly the fetal souffle. During labor the symptoms are: (a) tedious, due to feebleness and slackness of the pains, the membranes being ruptured and dilatation of the os complete, and there being no apparent obstacle to deliver on the side of either mother or the fetus, sometimes the pains continue regularly but the advance of the fetal part is slow and difficult. The pains are, as it were, cut in half and are not as expulsive as they should be. There is a painful point at the umbilicus corresponding to the fundus uteri. The uterus remains hard during the intervals of contraction,

and there is a species of erythism similar to that produced by ergot. The movements of descent and retreat of the head are not really apparent at the lower part of the pelvic canal. They are rather due to the resistance of the perineum and of the soft parts, the umbilical souffle; irregular fetal heart sounds, a premature flow of meconium, hemorrhage before or just at the moment of fetal expulsion, and lastly, tension of the cord only appreciable exceptionally and very late. These are the principal signs. They are not characteristic, for they may all occur with other conditions and they may all be wanting."

In looking over this case and comparing the symptoms as above recorded, it seems that there must have been a separation of a portion of the placenta caused by a sudden movement of the fetus making too much traction upon the cord. The fetus being suspended, as it were, by the cord; then the membranes ruptured, which allowed the uterus to contract upon the fetus, and in that way checked the hemorrhage. Concealed hemorrhage occurs after separation of the placenta during labor, but I have not been able to find a case recorded occurring before the completion of the term, and causing a premature delivery or abortion, and the case is offered as it suggests another danger to the pregnant woman. It helps to confirm also the observation made by Carus and Froebel that shortness of the cord had been found coincident with certain deformities.

PUERPERAL FEVER TREATMENT.

BY

GEORGE WIGG, M. D.

I AM confident that I cannot present anything new for your consideration in the treatment of the malady we are now considering, but I do know that from the vast mines of medical literature I can produce forgotten pages of the past treasures that will reflect the truths taught by the fathers of our faith, ere they passed over to the "brighter side of life."

Should you be called to see a case of puerperal fever at the very onset, I know of no remedy that will help you out better than aconite, but, should the disease have already manifested a threatening tendency, or be centered in the uterus, other remedies will have to be studied.

The following are the remedies most likely to be needful:

Bell.: If the disease is centered in the uterus, and the following symptoms present: Pains that come and go suddenly. A sensation in the abdomen as if clasped with claws. Abdomen distended and sensitive to the slightest touch. Chills over the chest, shoulders, back, and limbs, then hot; then chilly again. A bearing down with an involuntary straining force; she says "I can't help it." Very sensitive to light and noise; jarring the bed or walking heavily disturbs her. It appears to her as if all the parts would issue through the vulva. Headache, and face red. If the pulse is quick and weak, and there is violent throbbing in the frontal head, with intense fever, restlessness, excessive pain, abdomen distended, and skin cold and clammy. Consider well. *Verat. viride*.

Nux vomica is a remedy of great value in this disease, and is indicated by a pain in the neck of the uterus, as if bruised. Frequent desire to urinate, with pain, scalding,

and burning. Constipation, accompanied with frequent ineffectual urging to stool; pains in the small of the back, which are aggravated on motion. Nausea, with a desire to vomit, or actual vomiting; pain in the head. Headache; with a feeling as if the head would burst. She is so giddy that she cannot sit up in the bed; rushing sounds in the ears, and intolerance to light and sound.

Canth.: Should be given if there is great heat and burning in the abdomen; debility, restlessness, and trembling of the limbs; abdomen swollen, and tympanitic above, but yields a dull sound below; constant painful urging to urinate, passing but a few drops at a time.

Byronia: Abdomen greatly distended, and sensitive to contact and motion. The pains in the abdomen are of a stitching, burning nature; lochia suppressed, with a splitting headache. She says she knows her head will split open. Yet she wants to lie perfectly still, because the slightest motion aggravates the pain; there is great dryness in the mouth, without thirst, or else great thirst, so great that she drinks glass after glass of water; perspiration in short spells, but only on single parts of the body; if she sleeps, she has frightful dreams, almost always constipation present.

Rhus tox.: Offensive lochia, lasting too long, or often returning; milk suppressed; great restlessness; cannot lie still. She changes her position constantly, because the relief it affords is only temporary. The fever is apt to be rather slow, with dry tongue; She can scarcely draw up her legs, they are so helpless; pains always worse after midnight.

Coffea: Should the fever have been caused from mental excitement, and should there be frequent crawling, with feverish warmth, tongue moist, absence of thirst; delirious talking, eyes open and shining; violent abdominal pains.

Arsenicum: When there is great restlessness and prostration, with burning, throbbing, lancinating pains in the abdomen; anguish with fear of death, sallow or livid com-

plexion. Burning heat, dry parched lips; thirst for frequent sips of cold water, nausea and vomiting, dizziness, headache, delirium; small, feeble, intermittent pulse; desire to be kept warm.

Calendula: After instrumental labors, when the cervix uteri or perineum are lacerated. Where the vulva has been long distended and the parts are tumefied and lacerated. Chill without thirst, fever with thirst, and aching all over. If you fail with *arnica*, try *calendula*, and do not forget *hypericum*.

Kreosote: When after childbirth there is a putrid state of the womb; loss of memory; she thinks she is well; discharge of dark, offensive blood from the womb; labor-like pains in the womb; drawing in the upper abdomen, extending to the small of the back, and pressing forward toward the lumbar vertebræ, with flushes of heat on the face and palpitation of the heart.

Baptisia: Has always extreme restlessness, but motion does not relieve. Septicæmia with typhoid symptoms: fetid lochia; great prostration; abdomen distended; flatulency with rumbling; she feels as though vomiting would relieve her; sharp, shooting pains in the bowels; urine dark-red and scanty; difficult breathing on lying down, but without constriction of the chest; headache as though it would fly to pieces; thinks if she could only get the pieces together she would be able to get some sleep.

Secale: Has a tendency to putrescence; discharge of a sanious blood, with tingling in the legs and great prostration; urine suppressed; burning fever, interrupted by shaking chills; small sometimes, intermitting pulse; abdomen distended, but not very painful; pain at the pit of the stomach; vomiting of decomposed matter; offensive diarrhea; bed sores, which tend to become gangrenous; she has a mania for light; laughs, claps her hands, and is vociferous; she tries to jump out of bed, or climb out of the window; terrible forcing, bearing-down pains.

Stramonium: Mental excitement and delusions very marked; she thinks rats and mice are under the bed and looks to find them; thinks that she lies double or crosswise in the bed; the head is jerked up from the pillow and falls back again; she awakens with a shrinking look, as though afraid of the first object she sees; she desires light and company; is disposed to talk continually.

Hyoscyamus: Typhoid state; either complete apathy, or else great excitability, spasms, jerkings, and wild staring; throwing off the bedclothes and making herself naked; she seems to be bewildered by hallucinations that are only half real. This remedy is especially useful when the inflammation has developed from emotional disturbances.

If the inflammation has been developed after a fit of anger, *chamomilla* may have to be resorted to; especially if the breasts are flaccid and empty; whitish diarrhea; lochia scanty; abdomen distended and sensitive to contact; heat and great thirst; she is ill-humored and can scarcely treat her attendants with civility. There is the quarrelsomeness of *hyos.* but no delirium. The patient has her full senses, but is unbearably cross.

Merc.: Lancinating, boring, or pressive pains in the genital organs; very sensitive about the pit of the stomach and abdomen; moist, soft tongue, showing the imprints of the teeth, accompanied occasionally with great thirst; profuse sweat, without relief; symptoms worse at night.

Colocynthis: Severe, cutting, colicky pains in the bowels; excessive tympanites, thin, watery diarrhea. During paroxysms of pain: complexion pallid; skin alternately cold and hot; pulse quick; distressing vomiting. This remedy you will find well indicated when the tympanites is excessive.

Verat. alb.: Violent vomiting and diarrhea; suppressed lochia; icy-cold extremities; hippocratic countenance; cold perspiration; cold breath; threatened collapse.

These, ladies and gentlemen, are the main remedies in

the treatment of this disease, but complications may arise calling for any remedy in the *materia medica*.

Should the uterus contain decomposed placental debris, strips of membrane, or retained coagula, it will be worse than folly to try to treat the general symptoms, expecting to cure the patient until the offending particles are removed.

Hence it may become necessary to use hot intra-utrine douches every hour. The temperature of the water should be 85° to 95°, and contain either carbolic acid, iodine, permanganate of potash, or bichloride of mercury, 1-4000.

Before using the intra-uterine douche see that the vagina is well washed out with a two per cent. solution of carbolic acid. Remember that hot vaginal douches, warm baths, and the application of flannels wrung out of hot water to the abdomen help to relieve pain, and may contribute to the absorption of the exudate. When, however, it has gone on to the formation of pus, as indicated by the condition of the patient, the seat of the deposit must be discovered and, if possible, evacuated, after which the local treatment must be as for that of an abscess.

MECHANICAL MASSAGE VS. FARADIC ELECTRICITY.

BY

FLORA A. BREWSTER, M. D.

IN health there are various series of interior motions, which are maintained by the ordinary activities of life. There is change of place, of cells, of fluids, of organized and semi-organized substances; there is gliding of membranes, of fibers, and various other anatomical parts constantly taking place.

In diseased conditions we find some of these motions changed or perverted. Persons pursuing mental occupations or monotonous avocations are liable to engender too much motion in a limited portion of the body, while other portions are compelled to suffer from the need of motion. Unbalanced interior nutritive activity will surely follow, and the various physiological functions, which depend largely upon motion for their stimuli to activities, become sluggish, and a morbid state of various tissues results. We may then have congestions, inflammations, neuralgia, rheumatism, gout, and a host of other maladies.

It was due to a careful study of these laws and functions which led Ling, the father of the "Movement Cure," to devote his life to the teaching of his theories. One of his laws was as follows:

"Nutrition or muscular development of any part of the body occurs in direct relation with the active movements to which the part has been subjected."

Ling contended that mechanical agencies could be employed therapeutically, as well as chemical and galvanic agencies, as it is an established fact that the "living fiber" equally reacts from mechanical as from chemical or galvanic excitation.

Curative movements were first practiced by Ling at Stockholm in 1813. He was himself the victim of a grave malady of the lungs, and noticed the favorable effect that movement had upon his own health. From these observations he formulated a score or more of laws which are terse and pointed and cover the entire field of physical development.

It was my privilege to visit several sanitariums where curative movements were used before I myself invested in these machines, and I have received abundant evidence of their curative action, and have been impressed with the fact that the results obtained were very similar to those we get by general or local faradization of the body.

Congestions are removed with equal facility by stimulating the nerve centers, either by faradization or by rapid vibration, from a machine constructed for this purpose.

That the galvanic current acts chemically upon the blood and tissues has long been known. If a strong galvanic current be passed through a piece of beef the chemical changes may be readily observed. If the current be concentrated, as when passed through needles or a wire for electrodes, the tissues may be actually burned up or destroyed by the galvanic current, but no effect whatever can be observed when the faradic current is passed through lifeless tissues.

We may therefore conclude that the faradic current is only active on living tissues or tissues capable of motion. Chemical changes in the tissues, however, do follow from the use of the faradic current, but these changes, so far as I have observed, are identical with those produced by rapid vibration of the tissues, or chemical massage.

This view is still further enhanced if we carefully study the pathology of diseased organs.

All disease is manifested as altered, restricted, or exaggerated action of portions of the nervous system, and hence remedial means must increase, repress, or regulate

the action of the nerve centers which originate the nerve power which controls the diseased organs.

The nerve centers may contain too much blood and be in a state of hyperæmia; or they may contain too little blood and be anæmic; or the nutrition of the cerebro-spinal axis may become so impaired as to allow morbid deposits in, or degeneration of the spinal cord.

Any remedial means which will regulate the unbalanced nutritive energies of the nerve centers will cure the patient.

Vitality is the manifestation of force or action by organized substance; while pathology and disease imply perverted action and consequently defective *motion* of constituent parts of the animal structure, and therapeutics consists in the correction and restoration of these *motions* to the normal standard.

When an organ is congested or inflamed we have an excess of blood in the affected part and a stasis or retardation of the flow of blood through these tissues. Hyperæmias and morbid growths with perverted physiological activities are the result.

Boys as a rule are more active than girls, and are therefore less liable to passive congestion and their sequelæ.

A proper use of the gymnasium and the bicycle with horseback riding will, I believe, be of great assistance in educating our girls to a more active outdoor life and a consequent diminution of pelvic troubles, but it is a fatal folly to urge a woman who is so weakened from inactivity as to be loaded with foreign matter in the shape of pelvic congestions with misplaced organs, etc., to take these violent exercises.

In these cases, if we can excite the adjacent tissues to increased physiological action, the nerve stimuli will also affect the suffering organ and compel it to make an effort to regain its lost equilibrium.

I have used the faradic current upon my own body, and have noticed the fatigue which follows when strong mus-

cular contractions are produced, and the pleasant, soothing effect of a current of high tension and rapid vibration, if the treatment be brief.

About a year ago a lady from New York consulted me for pelvic trouble. I found a chronic congestion of the uterus with enlargement and prolapsus, but very little tenderness to pressure. This condition, a large experience has taught me, can be speedily relieved by daily application of faradic electricity.

I now had a chance to test the effects of movements, and sent her to Dr. Taylor's Movement Cure Institute in New York City. In one month she returned to me, and I found that the parts had already regained their tone and that the uterus was in its normal position.

Later I visited the Institute myself and had slow and rapid vibration applied to my own body by means of machines.

In mechanical massage a larger mass of tissue is subjected to gentle and rapid vibration. This stimulates the nerves and increases the flow of blood to and from the parts. This is exactly the result that we get from general faradization.

My observations have led me to conclude that the physiological effects from the faradic current and rapid vibration are quite similar.

The *sensations* from the vibratory machines are, however, more pleasant. This is, I believe, due to the fact that the interruptions of the faradic current are seldom even, and hence the vibration of the tissues are jerky and disagreeable. In mechanical massage there is no exposure to cold from wet electrodes and damp clothing, and the treatments are less troublesome to both patient and physician; indeed a well-trained nurse as assistant can administer the treatments.

The results obtained cannot be produced by movements applied with the hand. The hand may be used to mechani-

cally empty blood vessels and sooth excited nerves, but it cannot possibly produce the extensive tissue changes produced by vibration of the tissue in masses.

In cases of intense local inflammation with heat swelling and tenderness no sensible practitioner would think of applying vibrations or massage directly to the affected parts, and yet we frequently find that the faradic current has been applied directly to inflamed tissues. Several such cases have recently come under my observation and in every instance the case has been aggravated; indeed, in one case the patient's life was in jeopardy, with a history of aggravation from the time the faradic current was first applied.

This patient had a fibroid tumor with extensive adhesions and considerable inflammation. She is now under treatment with the *galvanic* current applied directly to the tumor tri-weekly.

The tumor has diminished in size, is soft, and is freely movable. It, however, required five or six weeks' treatment to reduce the inflammation and get the patient strong enough to come to my office for galvanic treatments. Had she continued using the faradic current I am convinced that the case would have speedily terminated fatally, for when I first saw this patient she was in bed, feeble and pallid, unable to move without intense pain.

No physician could have been so foolhardy as to even think of massage or movements of any kind for this case, and yet she had been using the faradic current under a physician's directions for weeks.

We all know that in acute rheumatism the patient cannot bear massage or motions, and yet we sometimes find them bravely trying to endure the faradic current with the desperation of hopelessness. Subacute rheumatism is sometimes benefited by motion skillfully applied, and chronic rheumatism is always benefited, but it is absolutely cruel to apply motion where it can only do harm by exciting instead of allaying inflammation.

Motion administered to allay inflammation should be applied to adjacent or remote tissues in order to excite a flow of blood *from* the congested organs or tissues.

This subject deserves more attention than it has hitherto received, for it is an agreeable and powerful curative agent in all cases of perverted nutrition.

MARASMUS.

BY

GUY E. MANNING, M. D.

MARASMUS is a slow wasting away of the whole body, a gradual and general atrophy taking place in infants, usually during the first year of existence, though not necessarily confined to that period. Inanition, malnutrition, malassimilation, simple atrophy, are synonymous terms. But by whatever name you are minded to designate it, or no matter how humble the idea may be, it is a simple starvation, a starvation often in the land of plenty.

It is a most frequent cause of mortality in early infancy, and yet I have looked in vain among many authors for any information upon the subject. Its being so closely allied with other diseases, principally catarrhal enteritis, or tabes mesenterica, have caused many to consider it a symptom, more than a disease, with its own train of symptoms similar to the above-mentioned ailments. Strumpel, for instance, says: "In almost all long-continued cases, however, the general disturbance of nutrition, the atrophy (athrepsia) of the child, takes the first place in the picture of the disease." This in speaking of intestinal catarrh of children. He then goes on to describe the symptoms, which are wholly those of marasmus, and continues: "From this sad condition just described, unfortunately so common in practice among children, we can usually recognize the condition of things at a glance, for, by far the larger part of the cases called 'pedatroph,' are due to chronic, digestive disturbances," yet it appears to me to be most certainly a disease of itself: that it has symptoms of its own, and though it may at times have a similarity to other diseases, it exists by itself. Starr, in his late work on diseases of children, so considers it, and devotes quite a little space to it.

Those whose labors are connected with dispensary or hospital work are most familiar with it, and, perhaps, like myself, hate to see the development of its first signs. Among the better class it is not so common, as the mothers are not lacking the necessities of life, and the children can have the care and attention necessary to prevent or arrest such a downward course.

From what has been said, you will notice that marasmus is most frequently encountered among the children of the poor, in hand-fed babies, and especially among children in the cities. From the nature of the disease this is to be expected, but not alone to this class is it confined. It is due to insufficient nourishment, and food may be insufficient in two ways, in quantity and in quality. Under the first head quantity, occurs a breast secreting good milk, but a scanty amount, too little for the nourishment of the growing child, or it may include, on the other head, a breast secreting an abundance of a poor, watery fluid, lacking fat, lacking cream, lacking salts, and of about as much value as a supporter of life as so much water would be—in fact it is nothing but colored water. With hand-fed babies, it usually happens that they are not underfed, but overfed, a condition that can also produce similar results. Under quality comes improper or impure feeding. Where babies are hand-fed, often ordinary care and I am sure ordinary sense is not used in the preparation and giving of food to infants. I am no lover of baby foods, those hundred and one mixtures claimed to contain the proper nourishment for infants, and which, in many cases, under analysis, have proved to contain harmful constituents, or to be in *no* respect superior as a food to good wheat flour. In the majority of cases, they are not what the child needs, and are very apt to increase the trouble or cause other affections of the alimentary canal. I am not going to individualize the different infant foods. I class them as a whole in my remarks. Some of them may have virtues,

and I have seen many children raised on them, but my use of them has not been very satisfactory, and, as I have said, I am no lover of them. But, leaving those preparations, children, aye infants, before they can boast of a single tooth even, are given bread, mush, starchy foods, or, horrible to relate, meat. Is it any wonder that under such treatment, the foundation is laid for malnutrition, for marasmus, for death? It makes no difference what the circumstances, or how outlandish the idea may be, because Mrs. A. gave her baby food from the table, and the child did not succumb, this mother must do the same, and Mrs. A. is the cause directly or indirectly, for the suffering of two children, for they both will sooner or later show the effects of such treatment, if not in any serious and fatal condition, in a life-long dyspepsia or irritable canal.

The feeding-bottle has also much to answer for in the production of marasmus, likewise carelessness and indifference of nurses. In breast milk, the quality will be affected by dietetic or emotional influences.

Symptoms.—The child for some time has shown no gain in weight, seems to be at a standstill, and soon its face and limbs become thinner, the muscles flabby, the lips thin and colorless, the mouth is drawn, the face pale and gradually becomes wrinkled, the skin shows a dryness and roughness, and with this wrinkled appearance gives the child the look of an old man, that would be quite comical were it not for its sadness. The eyes are deep set, but from the wasting of the face, appear large, though lusterless. The anterior fontanelle is sunken, often showing each heart beat of the little sufferer. The tongue is furred; and aphthous patches often are found in the mouth. Every rib can be traced, while below, the abdomen bulges out in the marked contrast. The limbs are covered by the same dry parchment-like skin which hangs in folds. Cold extremities, often clammy, with little claw-like fingers and hands. Intertrigo easily develops, especially between the thighs, around the

anus and genitals. The child is cross, cries almost constantly, sleeps but little, and then disturbed and anxious. When fed, he at first eats ravenously, but soon drops the breast or bottle, and cries, only to repeat the process, telling us without words that he is suffering from hunger which cannot be satisfied. In other cases the child seems heavy and sleeps almost constantly, falling asleep often, with the nipple in his mouth. Perhaps he will suck his fingers till sore and raw. The bowels are constipated and the stools undigested, but later in the case or perhaps existing from the very first, are enteric symptoms, colic and diarrhea, the stools being green and covered with mucus; vomiting of milk in curds, or cheesy masses; nothing will remain on the stomach. Perhaps a brain irritation or a reflex will develop in the boring of the head into the pillow, a restless and almost continuous turning of it, or a moving and rolling of the eyeballs ending in a squint—in fact, the child appearing to be in a convulsion, and in these severe cases convulsions often precede death. In those cases in which the enteric and mental symptoms are not so prominent there is an increasing weakness and loss of strength, until the vitality becomes too low to support life, and the child dies from sheer exhaustion.

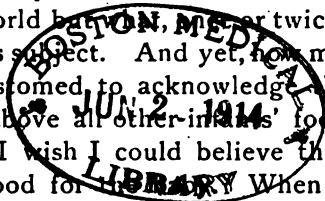
The pathology of the case is simple, and shows what you would naturally expect—an atrophy of the muscles and tissues and an absence of fat. There is often, if not in all cases, fatty degeneration of kidney, lungs, and brain, and if brain symptoms are prominent, hemorrhagic effusions are to be found in the cranium.

Diagnosis.—A simple atrophy, used in the sense of emaciation, is apt to occur in any long-lasting or severe disease, and is an attendant of tuberculosis in all cases, but in the latter, examination of the lungs show bronchial râles, while marasmus does not develop any physical chest signs. There is also a cough and hectic fever in advanced tuberculosis. It is often difficult to distinguish some of the

later symptoms from tubercular meningitis. The absence of the hydrocephalic cry, diarrhea instead of constipation, the depressed fontanelle in place of a bulging, and the history tend to discriminate.

The prognosis must be guarded. If a simple atrophy, and seen before a child is too weak, the prognosis is good; if at all tubercular, doubtful; if severe diarrhea and vomiting, then I consider it bad.

Regarding the treatment, the main thing is the diet. Examine the food, and in nine cases out of ten change it. And right here comes the difficulty. This subject of infant diet has been discussed and re-discussed; every physician has a formula, every one his favorite food. Not a medical journal in the world but twice a year, contains an article on this subject. And yet, how many agree? We have been accustomed to acknowledge the superiority of mother's milk above all other infants' food, and yet a Dr. Taylor says: "I wish I could believe that mother's milk was the best food for infants." When all is said and done thoroughly, careful hand-feeding is about the safest and most reliable," while another "has found germs in nearly every specimen of human milk analyzed." I cannot further discuss the subject here, but I for one cannot agree to go back on the human breast—the best nursing bottle ever invented, and the milk that flows therefrom the finest that was ever prepared for infant feeding. This, of course, in a healthy, strong mother. If the breast is poor, thin, watery, then most certainly stop it. If too scanty, but rich, supplement it; examine each case, discover the cause, remedy it if possible. If the infant is on artificial food, and does not thrive, especially after one or two changes in food have been made without success, do not waste further time; resort to a wet-nurse. Such a course will sometimes succeed when nothing else will. And in wet-nurses, let me say, be careful always, besides the good health, to obtain one whose child is very nearly of the same



age as your patient, or the milk will be too strong, and the harm you are trying to avert will not be remedied.

For a proper artificial food, my preference is sterilized milk, diluted, perhaps, with lime water, and cream and sugar added, according to age and character of milk; and in the case of marasmic children dilution and proportion of cream will be regulated by the digestion of the child. I know many of you will not agree to sterilized milk; you will remind me that it arouses the scorbutic taint in the child, which might never have developed; that it does not kill all germs unless brought to the boiling point, and then such milk is injurious; that it requires more sterilized milk than raw milk to produce an equal gain of weight, and many other arguments. But authorities have refuted all these statements, and as far as our knowledge goes at present, I will take my chances with sterilized cow's milk. The decrease of infantile death rates in cities and private practice where this subject of sterilized milk has been carried out properly is too convincing to be taken for naught.

If there is much vomiting and sour eructation, lime water is a preferable dilutant. Barley water is useful if vomiting of curds. Pathogenic milk powder added to the milk is spoken of favorably by some. If much vomiting and diarrhea, I often use arrowroot mixed with milk and water or even water alone until the stomach is "settled," or until a stronger food can be borne. What is known as a flour ball is often advantageous, temporarily. The white of an egg, beaten up in water and sweetened, and fed either from the bottle or spoon, is often agreeable to the child, and, being almost pure albumin, will sustain life for a long period. Anointing with cod liver oil or olive oil once or twice a day, under the arms, over the chest and abdomen and between the thighs, has proven with me to be a most satisfactory way of adding to the child's nourishment.

Look to the bottle, for an imperfectly cleaned bottle and

nipple can do more harm in one nursing than you can remedy with food or medicine in several days. A plain nursing bottle with rounded edges and an ordinary black nipple, not too large, are my preference. Keep the abdomen warm with a flannel band, and watch the feet and extremities to prevent their becoming cold. If the weather permits, the sunlight and fresh air are to be taken advantage of. Sponging with warm water before the anointing with the oil keeps the skin active, is soothing and resting, and favors absorption. Even a warm bath in most cases can be given without danger. Wash out the mouth with boracic acid solution after each nursing, and keep the nipples, either flesh or rubber, free from any contamination.

Dr. Steele of Philadelphia, in the *Hahnemannian Monthly* for March, in a paper upon circumcision, cites five cases of marasmus and one of malnutrition, in which the operation was followed by perfect recovery and health. Two of the cases mentioned were at death's door, one not being expected to stand the operation. Unless a very marked case of phimosis or lengthened prepuce with marked nervous or other troubles, I would not feel justified in operating, though I can imagine a case in which the child's growth and health might be affected by the lengthened prepuce, especially if a pinhole opening is present; but I have never operated with the thought of circumcision being a cure for marasmus.

In regard to remedies I will say it is hard to determine just how much they can be relied upon; not that I do not consider them beneficial, nor that they have not accomplished all that could be expected from them, but so often the child is so weakened and almost lifeless, that it is impossible to recuperate them, or give them vitality enough to withstand the ravages of the disease, even though the acute symptoms may have entirely subsided under treatment.

We have quite an extended list of remedies, but ordinary

cases sift them down to some eight, or, at most, ten : arsen., abrotan., calc. carb., calc. phos., iodin., magnes. carb., sars., and sulph, with hepar and phos. a "good second."

My first thought is usually of sulph., that standby, which so generally fits the children of the poorer class at least. The wrinkled, dried up "old man" appearance; the parched skin, with tendency to intertrigo and eczema; the offensive odor of the body and the dislike for being washed; the hot head and the cold feet; the voracious appetite with 11 A. M. hunger; the early morning diarrhea of that slimy, green, offensive character, all prominent symptoms of sulph., are so frequent in marasmus.

Calcareo carb., with its voracious appetite but still the emaciation progresses; atrophy of all the body except the abdomen, which is disproportionately enlarged; cold sweat on head; feet damp and cold; stools green, watery, and sour or clay-like; vomiting of sour food and curds often has a place early in the disease.

Iodine has the same desire to eat frequently with loss of flesh as calcareo carb. The skin is more like sulphur, dirty, yellow, and dry; then the glandular trouble shows forth here as usual in iodine in the swelling of the mesenteric glands; abdomen is large and puffy; night sweats and diarrhea.

Calcareo phos.: A scrofulitic diathesis with malassimilation; the bones are not developed, the skull is thin and soft, and both fontanelles remain open; the abdomen here is more shrunken than in calc. carb., diarrhea of watery, slimy stools; a craving for salt food.

Arsenicum has a pale waxy look, though the skin is dry, but the arsenic symptoms of prostration, great restlessness and burning thirst are most prominent; instant vomiting of food and drink, thereby giving relief; diarrhea of a green, slimy character, undigested and most offensive.

Magnesia carb. is a useful remedy, where vomiting and a diarrhea of a sour, green stool like the scum of a frog-

pond is present, abdomen is bloated, glands are swollen and great emaciation is present.

Sarsaparilla is the remedy when the case is of a later stage: the disease is *fully developed*, the emaciation is great, the skin lying in folds; the neck is especially thin; uneasiness before urination, the urine containing a white sand; stool with much flatulency; all kinds of eruptions develop, which are moist; offensive sweat of body.

Abrotanum; also a late remedy, but the emaciation is of the legs mostly; face has the same cold, dry, wrinkled appearance as sulphur; more of a constipation than diarrhea is present; a voracious appetite; distended or bloated abdomen, but lumpy and irregular; child cross and peevish.

In hepar the child looks plump, but on examination the muscles and flesh are flabby and poorly nourished: sour smell of the child and also of the stools, which are undigested, white, and painless; every draught of air produces a cold.

There is a gushing stool with great exhaustion in phosphorus, and the tubercular build and appearance of the child, with probably a hectic flush.

In borax you will find an efficient remedy, inasmuch as a hot mouth, cheeks, and tongue covered with aphthæ, which bleed easily, a fear of downward motion, and a nervousness and frightened condition, shown by the terror and screaming, on awakening, are frequent symptoms, and borax is especially a children's remedy.

If offensive smell to whole body; offensive, fluid stool, skin about head and face covered with boils and crusts, from which exude a yellow discharge, and if worse at night or when the weather changes, think of psorinum.

A similar condition is found in graphites as far as the offensiveness of all discharges are concerned, but psorin. is of a more disagreeable, disgusting character in its skin affections and its discharges.

Bear in mind *argentum nit.*, if there is a green, fetid mucous stool, much flatulency, and emaciation, beginning in legs and working upward; *antimonium crud.*, if there are watery, curdy stools after nursing; if vomiting of food and drink as soon as taken; if tongue is thickly coated with white, and the child is fretful and cross, crying when touched; *arsenicum iod.*, if a constant, copious, watery diarrhea, incessant vomiting, offensive and excoriating stool, rapid emaciation, and a purple dark skin; *æthusa*, if violent, explosive vomiting immediately after nursing, then falls asleep, and awakes to nurse with same result.

A *lycopodium* child is irritable and nervous, large head, bloated abdomen, puny body; appetite excessive but soon satisfied; red sand in the urine.

Silicea also has a large head and small poorly nourished body, but the sweating of the head, and aversion to mother's milk are characteristic symptoms.

Baryta carb., in dwarfish children with poorly developed minds; *opium*, if much stupor in little dried-up babies; *bell.*, if prominent brains symptoms; *kreos.*, if tendency to tuberculosis; *nitric acid*, if syphilitic or mercurialized, and *calc. iod.*, if scrofulous, are liable to prove useful at any time.

ASEPTIC MIDWIFERY.

BYSUSAN J. FENTON, M. D.

WE are told in Sacred Writ that "only he that hath clean hands and a pure heart shall ascend into the hill of the Lord"; and just as reverently would I say, only he with clean hands and a pure heart (for a clean body generally accompanies a pure heart) shall enter the obstetric room.

How meager are the directions for cleanliness (asepsis) in our text-books on obstetrics. In many of them there is not one word of teaching relative to that absolute cleanliness so necessary to perfect success in midwifery. And by perfect success, I do not mean simply the patient getting up on the tenth day, but, getting up with healthy endometrium, healthy tubes, and healthy peritoneum.

Even Moses, while giving quite elaborate directions for the cleansing and purifying of the patient, says nothing to the midwife. I think perhaps the patient may have had one advantage in the Mosaic days, from the fact of less vaginal examinations during labor, thus greatly lessening danger of puerperal sepsis. I suppose the cases of puerperal sepsis then were traced, as they have been with us until a few years ago, to every cause under the sun,—and sometimes to a cause above the sun, viz, "dispensation of Providence"—rather than to a dirty examining finger with its overhanging roof of germ nests. I sometimes wonder if finger nails are not a concession to His Satanic Majesty, there may be so many germs of death and disease lurking in their recesses.

In searching for a scientific truth, instinctively we turn our eyes to the great centers of the world where thought has crystallized into action. If we look to the centers to

find what asepsis (and I understand antiseptis to be as Grandin defines it, "certified asepsis"—cleanliness) has done for midwifery, we find it has caused a remarkable lessening of maternal mortality.

In Vienna a few years ago the death rate in the lying-in hospitals was something appalling. During the epidemics of puerperal septicæmia, which were not infrequent, out of thirty or forty women confined in one night, in three days' time not ten would be living. No wonder the physicians in charge began to investigate their technique to see where it could be improved. Now, with perfect asepsis and abolishing vaginal examinations, death is of rare occurrence.

In Zweifel's hospital, since the introduction of perfect asepsis,—and in large hospitals perfect asepsis can only be obtained by antiseptis,—puerperal septicæmia is almost unknown. One exception to this immunity occurred there a short time ago, when one of the women, shortly after labor, developed sepsis, which rapidly spread through the whole ward until a number of lives were sacrificed. In rigidly seeking for the cause of the outbreak, it was learned that one of the students who had examined her before labor had not given himself the preparatory cleansing, in spite of strict instructions. He thought so much scrubbing and bichloride cleansing all nonsense, and many lives paid the penalty of his carelessness. Undoubtedly, septic material was carried into the vaginal canal by his finger, there to lie dormant, biding its time, until through an abrasion of the mucous membrane it could speed on its life-destroying mission.

Garrigues gives some interesting statistics from the Maternity Hospital of New York with which he was connected. Before the present aseptic measures were introduced, out of 3504 deliveries, there were 146 deaths. Since the introduction of asepsis (which is accomplished by antiseptics) out of 3170 cases of delivery, there have been only 30 deaths.

Better results still have been obtained in the "Sloan Maternity" of the same city, in which there is a record of one death in one thousand deliveries.

Dr. E. H. Grandin says he considers septicæmia after labor due in almost every instance to faulty asepsis. "Whilst, then," he says, further, "more accurate educational methods enter as factors in the science of obstetrics as practiced to-day, the fundamental reason why the mortality rate has been lowered is the recognition of the culpability of the man who neglects the laws of cleanliness (asepsis and antisepsis) throughout the conduct of labor and during the puerperal state."

Barker of Philadelphia says, "The rules of asepsis govern and are as applicable to the lying-in chamber as in the field of abdominal surgery, and while the result in one case may be death, in the other it renders a woman an invalid for life," which I think is stating the case very mildly. E. E. Moore of Washington, D. C., in writing upon the subject says, "In no department of either medicine or surgery have the principles of antisepsis been of more real value or borne richer fruit than in the field of midwifery"; and further, "To-day it is the rarest thing in the world to find an elevation of temperature after delivery in maternities where the principles of asepsis are advocated and carefully carried out, the old terms 'milk fever,' 'puerperal fever' being almost unknown. Indeed, the practitioner of to-day, whose patient has any rise of temperature above the normal, in the absence of any organic lesion or abnormal condition sufficient to account for it, knows [I should say *ought* to know] he has a case of sepsis to deal with and treats it accordingly."

Price of Philadelphia gives a record of nearly six hundred confinements in the "Preston Retreat" before a death, and that was from eclampsia. The highest degree of asepsis is accomplished there by antiseptics, as it is in all large hospitals and maternities. In view of the above facts,

I hold it to be the sacred duty of every physician practicing midwifery to use such means as will secure perfect asepsis in each case attended by him.

The first step to secure that end will be our obstetric bag, arranged to be ready at a moment's call. Every article in it will be thoroughly sterilized after each case, and wrapped in sterilized gauze. Our bag will contain obstetric forceps; obstetric gown; small jar each of vaseline and green soap; brush for scrubbing hands and nails; one catheter, glass preferred; one test tube each of silk and silkworm-gut suture; small glass jar with catgut suture in alcohol; perineal needle; needle-holder; two or three curved needles; one pair of scissors; one pair of forceps; bottle each of brandy, ergot, and chloroform; bichloride tablets; absorbent cotton, and some pieces of sterilized gauze.

With these and the immediate use of the brush and soap, and the consciousness that there has been no attendance recently upon septic cases, with the clothing covered by the long, clean gown, we may feel confident in our own cleanliness. But that is not sufficient. We must see that our patient and nurse are also aseptically clean. If we are so fortunate as to have a well-trained nurse, we may feel at ease as far as she is concerned, but very often we have a very different type of nurse to work with, when we must be very alert, not only in our instructions but in our watchfulness that they are carried out. Given a nurse of the Sairey Gamp type, and a determination to have good, clean work in the lying-in room, one needs the diplomacy of a Bismarck, the vigilance of a Napoleon, and the suavity of a Mme. Maintenon.

Preparation of Patient.—Our patient should have a bath at first sign of approaching labor, an enema, and a douche. She should have clean clothing and clean sheets to lie on. A piece of rubber cloth should be placed over the mattress and pinned at each corner. Over this a clean sheet should be smoothly spread, then another rubber cloth covered

with a thick pad ; or a pad made of layers of paper covered with cloth will do very nicely. Over this is placed a second sheet turned down one-half yard from the top. After labor, this sheet, with the upper pads, is gently drawn from under the patient, leaving her on the clean sheet with the mattress well protected.

As mentioned above, there has been a good, free use of the brush and green soap, the process of which is repeated during labor if the hands become soiled by any foul discharges.

Vaginal examinations are to be as infrequent as possible, and abolished altogether whenever the physician can accurately diagnose normal presentation, by abdominal palpation.

All manipulations of the cervix are to be avoided. The parturient canal should be protected from any rectal discharge by a pad of sterilized gauze kept over the rectum. All tears should be closed under aseptic methods, that no raw surfaces are left for absorption of septic material.

Aseptic Puerperium.—If there has been any surgical work, the same rules of asepsis which are maintained elsewhere in surgery should be rigidly observed. The parts should only be douched sufficiently to insure perfect cleanliness.

An aseptic pad to be used through the puerperium that I find very satisfactory is prepared by the patient before confinement. Cheese cloth thoroughly boiled and dried is cut in squares of thirteen inches, folded over a layer of absorbent cotton six by twelve inches, and tacked together on its three free sides. Eight or ten dozens are prepared, and kept in an aseptic condition by being rolled in a clean sheet till time of need. They are changed every two or three hours, the soiled ones being burned as soon as removed.

A UNIQUE MONSTER.

BY

GEO. P. HALE, M. D.,

ON Monday, April 15 last, was called to attend Mrs. L., II-para, in confinement. The messenger said to hurry, but when I arrived I found that the child and afterbirth had been born about forty-five minutes before my arrival.

The child presented a strange appearance. The body and extremities were perfect and presented all appearances of being well-nourished, but upper part of head was misshapen. Child weighed about seven pounds. There was no brain above the eyes, the top of the head being perfectly flat, and, in fact, somewhat depressed. The parietal and occipital bones were so firm that they could not be moved and there were no fontanelles. Attached to the back of the head by a short but broad pedicle was a globular mass, measuring four inches in diameter and $13\frac{1}{2}$ inches in circumference.

About two-thirds of this mass was covered with normal skin and the balance with mucous membrane; scattered over the membranous portion were several small nodules. This mass was at least one-third larger than the whole head should have been. It lived about fifty-six hours, and the whole body presented a livid appearance for twenty-four hours preceding death.

By grasping the pedicle between the thumb and finger and squeezing firmly the child was thrown into a convulsion presenting all the features of epilepsy, even to the frothing at the mouth. It would occasionally open the right eye, but never voluntarily opened the left one. The pupil of right eye was always slightly larger than that of the left.

Post-mortem, twenty hours after death: The scalp seemed very thick and firm. The coronal, sagittal, and

lambdoidal sutures were complete, there being no fontanelles.

Upon cutting through the gristle-like substance of the sutures and deflecting the bones it was found that the cerebellum only occupied the diminished cranial cavity. The mass behind was composed of the cerebrum greatly hypertrophied, together with about a teacupful of bloody water. The vertebral arteries were very large and the whole brain substance indicated a prolonged venous stasis.

Upon dissecting the pedicle I found a hole in the center of the occipital bone about a half inch in diameter and the pedicle composed of spinal cord the meninges and scalp.

It was the most unique specimen of cephalic trouble I have ever seen. The only information that I could elicit which would in any way account for such a freak was the history of a fall the mother sustained several months ago. She was going down a step which was icy and fell, striking the back of her head upon the step. This was the only blow or injury she received during her pregnancy. The parents are healthy, robust people, and the first child, now three years old, seems to be normal in every respect. The cerebrum had evidently escaped from the cranial cavity in early pregnancy, and the cranial bones settling down had become firmly knit together. The hypertrophy of the brain, I believe, was due to venous stasis caused by bending of the pedicle.

REFLEX SPASMS.

BY

JAMES T. MARTIN, M. D.

IN a perfectly healthy child digestion is carried on with so little apparent effort that we scarcely ever call to mind the intricate machinery that is set in motion whenever the proper food stimulus is taken into the stomach. Hence without entering into any discussion of the intricate physiological process of digestion, it will be sufficient for my present purpose merely to call attention to the fact that food is *the* stimulus that causes the normal reflexes that are concerned in the process of digestion.

So long as the stimulus is perfectly natural and the child entirely healthy nothing will likely occur other than normally healthy digestion; but let these conditions be changed either way somewhat, and an entirely different series of phenomena will arise. Take for example a strumous child, one inheriting a highly sensitive nervous organization and introduce into his alimentary canal food that is irritating and too hard to digest and either one of two things will take place: The extra stimulus will cause either a reverse peristalsis and the food will be rejected, or the reflexes will become disorderly or spasmodic and there will be general convulsions to deal with. These are not to be confounded with convulsions from disorders of the brain where the cause of the convulsion is centric or direct instead of peripheral. One of the most important predisposing causes of this disorder is hereditary. Children of syphilitic parentage, of drunkards, and of excessive tobacco users are much more liable than others to such seizures. Living in damp, poorly ventilated apartments, lack of proper food and clothing, all have their influence in lessening the resisting power of the individual and renders him much more

liable to these attacks. As to the character of the attack very little need be said farther than to note some important differences between these and epileptic or psychical spasms; more than nine-tenths of the spasms of children are of reflex nature. They are most always bilateral, while those from diseases of the brain are more liable to be unilateral or of isolated parts. The former are very often attended with high fever, while with the latter the fever is of but little consequence, while in either case the child may be poorly nourished. One of the most potent and exciting causes of infant reflex eclampsia is indigestible foods. Such foods cannot be easily assimilated by the system, and instead of causing the normal reflexes of digestion they irritate or overstimulate the nervous system and cause the general convulsions so often found in young children. I know of nothing that will be so trying to a young physician as his first effort to treat a child in spasms. He will find the house in an uproar, a sort of panic, as it were, while all the old women in the neighborhood will be on hand to give advice and criticise his efforts; and should he not succeed almost immediately in relieving the child, some good, kindly disposed matron will suggest that Dr. Pills is good on fits, and, if it was her case, she would send for him, hence he will be very fortunate if he does not lose both his patient and his head. The immediate treatment of such cases is very important. The relief of the spasm is the earnest demand of the parents, and but little delay in doing so will be tolerated. Should the immediate and inciting cause be something the child has eaten (which it usually is), the offending particles of undigested food must be removed from the alimentary canal as soon as possible. The easiest way to accomplish this is by moving the bowels with a full and copious enema, using olive oil if you like, and hot water. The child's hips should be raised much higher than its head while it is taking the enema, so that as much water as possible can be used. Kneading of the bowels with the hands will assist in in-

creasing the amount of water a child can take as well as loosen up the lodged particles of offending material. Unloading the lower bowel may produce sufficient peristalsis to carry the irritating substances past the point of irritation, but it will usually be necessary to unload the colon as well before the child will become relaxed. The treatment after the spasm has given away will be comparatively easy. All foods such as would be likely to cause irritation in the alimentary canal should be prohibited entirely. Among these we might mention blackberries, grapes, and all fruits having small seeds. Green apples, uncooked potatoes, and turnips, hard cooked eggs, or any other kind of food in hard lumps.

As to the medical treatment of this disorder, notes on a few remedies will suffice to give a general idea of the class of remedies indicated. The first and most important remedy in most any case of abdominal irritation is *cina*. It is the children's remedy. Given with the proper indications it acts with great celerity. When it is indicated, the sleep will be restless, the child will wake startled or in a fright many times during the night, much like *bell.*, with this difference: The *cina* patient jumps up in a fright, and it takes him some time to know what he is about or to really get awake. The mother will often tell you that she has frequently to shake the child quite hard before he will really awaken, while the *bell.* patient is wide awake the instant the fright comes. With *cina* it seems to come as a dream, while with *bell.* the cause seems external. Usually the *cina* patient frets all day while the *bell.* patient sleeps or is drowsy. With either remedy there may be nausea and vomiting, while *cina* may at the same time have a frothy, fetid yellow diarrhea with pain in the abdomen. He will be peevish and restless and not disposed to be satisfied with what is done for him, picks his nose, or if a very young child, rubs it very often. He will frequently turn white around the mouth, while at the same time the cheeks (one or both) may be very red.

Belladonna is the next remedy in importance to cina. The fever will be very high and does not rise and fall so suddenly as is often the case with the cina patient; the child sleeps a good deal more than ordinary. The least noise, especially an unusual noise, will startle the child and likely cause it to awake suddenly from sleep. The fever will last all day and most of the night, and longer if not relieved. There may or may not be nausea and vomiting, pupils of the eyes widely dilated, conjunctiva injection, and there will likely be some trouble swallowing.

Nux vomica is a very important remedy in these conditions. The class of cases to which it is more especially adapted have their origin in dietetic irregularities. The child for some time before the seizure will complain that the food hurts it immediately after having eaten. It is exceedingly cross and willful; disposed to fight rather than whine. Is troubled with constipation with frequent and ineffectual desire for stool.

Chamomilla with the laity is a panacea for most everything, but its sphere of action is much more limited in this class of cases than either of the other remedies mentioned, for the simple reason that it is more frequently indicated in a diarrhetic condition of the bowels than when there is constipation or obstruction. When indicated the child will be fretful, desires to be carried all the time, and really seems better when carried. The diarrhea is usually green with white, curdled, undigested pieces mixed with it, and is aggravated at night. The child has a poor appetite, and is not disposed to be friendly with attendants.

Cal. carb. is a very useful remedy, supplementary to bell. after the acute stage has passed away, should bell. not cure entirely. The child will perspire about the head very profusely. Its feet will be cold and damp, and the abdomen very large in proportion to the child. The child usually has a very poor appetite, or it may have a very good appetite and be very poorly nourished. Stools white and chalky.

Sulphur, bry., hyos., merc., podoph., and many others may be indicated in this trouble, but the ones given above are indicated more frequently than all others. In the discussion of these remedies I have said nothing about the symptoms during the spasm for the reason that they are of the least importance to the prescriber, inasmuch as a second spasm is not likely to occur as long as the child has proper food, and yet he may be ailing or in poor health until he receives proper medical treatment. Such cases will necessarily have to have close supervision of their diet until such a time as they are old enough to select for themselves foods that are not injurious.

THE CARE OF THE NEWBORN WITH ESPECIAL REFERENCE TO DRESS.

BY

LAURA C. BRICKLEY, M. D.

COULD Mother Eve have realized the enormous amount of labor and misery she was entailing on her descendants when she first awoke to the knowledge of the fact "That she had nothing to wear," she would have hesitated before gathering those leaves and trying to improve upon nature. She took the first stitch in our garment of slavery, and every woman has added another stitch, stitch, stitch, until life is simply a struggle to outdo the lily of the field. Even baby's coming means several months' of work before its advent, and upon its arrival what a getting together of linens, flannels, and starched frocks for the little stranger who has known naught but softest environments! It has always my sympathies on having its first toilet made. I have never yet put on the first dress without a mental apology to the little dear, realizing of what a source of trouble this is the beginning.

But a custom demands clothes, clothes there must be, as well with infants as with women.

That there are entirely too many clothes for baby thought necessary, we need only consider the squaw and her papoose, whose wardrobe is conspicuous by its absence. We civilized mothers could well take pattern, and make baby's life more comfortable as well as our own.

There is as much need of reform in infancy as later in life; perhaps therein lies the one practical point in the dress reform we hear so much about.

As Wendell Phillips says, "Begin a hundred years before a child's birth to make it," answers here as well as elsewhere, and we M. D.'s would have less work and poor humanity a better chance to enjoy the beauty all around.

Upon the arrival of the little one, after the cord is attended to (Dr. Sanders' method), it is well oiled with sweet or olive oil, or lard, wrapped in an old soft piece of muslin, and then well covered with a shawl, or blanket. Then it is given to the mother to be nursed, after which it is laid beside her on a pillow of its own, and *let alone* until it becomes adjusted to the new order of things.

As they generally make their appearance at the witching hour of midnight, the worst night of the week, they are not disturbed until next day, when they are bathed and oiled.

Then a shirt and dress is added. When possible the clothes should be made to hang from the shoulders.

One shirt is then all that is necessary and should be made to open in front, as they are so much easier handled.

I saw an advertisement that seemed to solve the question of how to keep baby covered at night. It was a gown with a draw string in the bottom and under the picture were these lines:

"Baby may kick, baby may squirm,
Baby may toss, baby may turn,
But she's covered."

When people learned that I did not have my babies

washed, I was put down on their black list, but when my little ones thrived without any mishaps, they said, "Well, it may be all right, but I always washed mine; so did my mother and grandmother, and you had better."

I am always careful to look after the bands, when they will insist upon using them, to see that they are not too tight, to see that it is not kept too warm, and is given plenty of fresh air and an occasional drink of cold water.

The clothes should not be over twenty-seven inches long, as a long dress and shirt are as much out of place on a baby as on a woman in the street.

Upon each visit baby is overlooked to see if it is clean and comfortable.

If you can persuade the mother to fuss as little as possible, to "let it alone," keeping it in as near the natural position as possible, her life will be less a burden, and our slumbers will be undisturbed when the thermometer is fifteen degrees below zero, and a ten mile drive does not seem to be the thing most conducive to our comfort.

APPLICATION OF THE FORCEPS.*

TRANSLATED BY

B. F. UNDERWOOD, M. D.

(Continued from p. 533, November, 1895.)

OBLIQUE AND TRANSVERSE APPLICATION, THE OCCIPUT
BEING IN THE LEFT SIDE OF THE PELVIS.

LEFT OBLIQUE ANTERIOR APPLICATION.

(The summit at the inferior strait, in left anterior occipital position.) The flexed head has descended more or less deeply in the pelvis; it is usually at the inferior strait, but not engaged, for rotation has not been made.

* From the French of Professor Farabeuf and Dr. Varnier.

The occiput is in front and to the left, in the direction indicated by the ileo-pectineal eminence; the vertex behind and to the right. That is to say, that the left oblique diameter of the pelvic cavity is occupied by the sub-occipito-bregmatic diameter of the head, and the right oblique by the bi-parietal. For the ears, which may be easily felt, particularly the posterior, are turned precisely toward the extremities of this right oblique diameter; they indicate that the parietal eminences and the cheeks, which are to be embraced in the fenestra of the blades, are equally turned; those of one side to the left and backward; those of the other side to the right and forward toward the right ileo-pectineal eminence (fig. 25).

The woman in obstetrical position presents the face of the plane of the inferior strait, but the engagement of the summit is not accomplished; likewise the descending pole, the center of the accessible hemisphere, is yet sensibly in the axis of the pelvic cavity, that is to say, toward the coccyx. Opening the lips of the vulva, the anterior parietal eminence may be perceived obliquely placed (the right in the left anterior occipito position), while the posterior parietal eminence, to which the first blade is to be applied, is deeply buried in the sacro-iliac cavity before which it rises almost to the superior strait.

The head should be taken in its length and by the sides, the concavity of the forceps being turned toward the nape of the neck which should be brought on the median line.

We say that the nape of the neck is in front and to the left, that the descending pole of the head is still near to the coccyx. Knowing that, hold the forceps to the outside with the two hands, in the position or attitude which it would have when the head has been properly grasped. The direction, left anterior, of the concavity of the instrument makes this oblique (fig. 25); and the left branch, the highest held in the left hand, should have the blade the

lowest, to the left and behind, embracing the left posterior parietal eminence; and the right branch, notched, of which the handle is the lowest, held in the right hand, with the blade to the right and in front, behind the right ileo-pectineal eminence, embracing the right anterior parietal eminence.

FIRST GENERAL RULE.—It is necessary to introduce first the blade, which will be posterior, to the end of having all facilities for placing it properly, for upon its proper placing depends the success of the operation.

It is the left blade in the present position, the left anterior occipital.

SECOND GENERAL RULE.—The blade introduced second should be above the first, making the handle necessarily cross on that of the first.

In the present position, left anterior occipital, the right blade, introduced second, is the female, notched; crossing

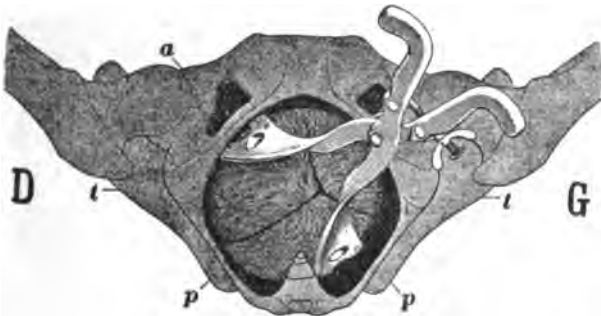


FIG. 25.

the first, which is the male, pivoted, it conveniently presents the notch to the pivot of the male blade.

Fig. 25.—Summit at the inferior strait, in the left anterior occipital position, showing the forceps regularly applied. Left branch (pivot) to the left backward, right branch to the right forward.

Therefore the left branch, pivot, held in the left hand, is the first introduced, preceded and guided by the right hand and placed at once to the left and posterior.

Supposing it to be placed and held by an aid.

The right branch, notched, taken in the right hand, will be then brought to the right and forward ; we say, brought forward and not introduced forward, where there is no place for the hand upon which a blade should always be introduced. In front and to the right, between the head and the pelvic wall, where it is necessary to place the blade, there is less space than to the right posteriorly, where there always exists between the region of the vertex and the pelvic wall, a wide space, the head not being applied against the sacro-iliac cavity as against the antero-lateral wall. In this wide space, right posterior, nothing is more easy than to introduce first the left guiding hand to about the ends of the fingers in forcing a little the flexion of the forehead, and then the right blade, as the left has been introduced to the left.

But if, in this manner, the left blade is immediately well placed, the right is improperly placed ; it grasps the sagittal suture, the vertex, and the forehead. That the right blade now introduced shall be properly placed upon the parietal eminence and the cheek bone near the ear, it is necessary, without the concavity ceasing to embrace the right cephalic ovoid, that it pass from the posterior on the side, and that of the side where the guiding hand has been still able to follow, it is advanced only to the point where, coming opposite to the first blade, it is symmetrical to that blade relative to the head. Then the branches should lock spontaneously, provided that the aid who had the first blade in charge has not committed the fault of allowing it to slip from its place.

This progress of the second blade (here the right) the operator provokes by giving a curved movement to the handle of the blade ; this movement in its entirety is known as "The Maneuver of Mme. Lachapelle."

You know the attitude of the head upon which you would apply the forceps ; you come, instrument in hand,

which you introduce and place in good position, the posterior branch (left branch, branch of the posterior ear); and the same with the anterior branch (right branch, branch of the anterior ear) introduced backward and to the right and brought to the front.

As usual, separate and render the branches of the forceps aseptic, blades oiled, having at hand a napkin moistened with an antiseptic liquid.

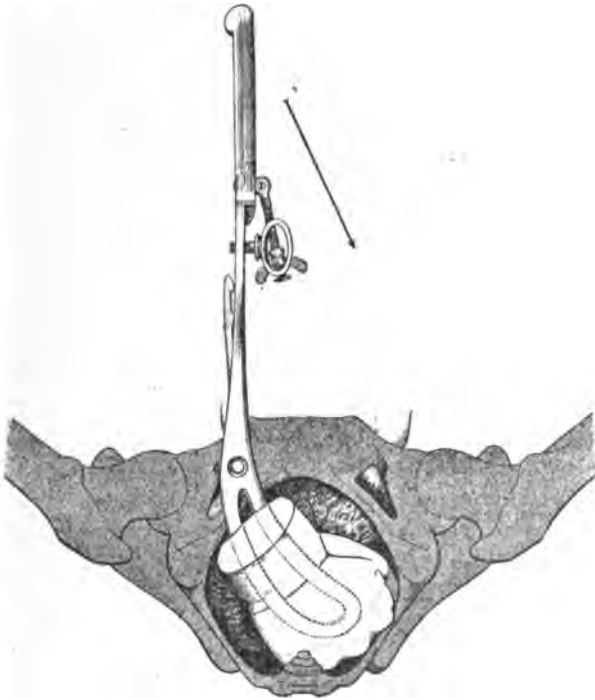


FIG. 26.

Fig. 26.—Summit at the inferior strait, left anterior occipital position. Introduction backward to the left, obliquely, between the coccyx and the ischium, of the first guiding hand (the right, thumb included), and of the first blade (the left). The sacro-sciatic ligaments arrest the metacarpophalangeal articulations, but the fingers penetrate their full length in the cavity.

MULTIPLE PREGNANCY.

BY

H. C. MORROW, M. D.

THE only experience in the line of multiple pregnancies that I can recall at this moment was one that occurred some three years since. The lady was not strong when she became pregnant. About a month before the date of delivery she received a severe fright, caused by a negro demanding admission at a late hour at night, with the purpose, as she believed, of outraging her person. Her husband was absent from home at the time. In a few days labor (miscarriage) followed and she was delivered of a small imperfectly developed female child. When the placenta came away, I found a dried-up, mummified fetus, that had evidently died at or about the third month. It had its own separate cord which was attached to the placenta a few inches from that of the living child. The cord was also dried up (atrophied) and withered to a mere string. The color of the fetus was a dirty white and the skin and flesh were like a piece of old dried leather which had been soaked in water. Its amnion had evidently been absorbed, for it had floated in the amniotic fluid of the living child, without doing its mate any harm by its presence. Here we have an exemplification of what nature does in an emergency. For some reason, either accidental, functional, organic, or constitutional, one of the *feti* died and became a foreign body in the uterus. The problem then was what to do with it. If it was to be thrown off that would cause the destruction of the living child, which would have been an unnecessary sacrifice, and nature never sacrifices a living creature if she can preserve it. If the dead fetus was to remain and decay it would have poisoned the amniotic fluid, certainly causing the death of the living child and probably,

by the same septic action, the death of the mother also. Nature then did the wisest thing possible, caused absorption to take place of all the tissues which would be dangerous to the living child or mother through the natural process of decay, in other words, she caused it to atrophy—to become a mummy.

The living child was born at the eighth month. It was weakly and delicate from the date of its birth on. It never nursed strong, had a little puny cry, and a month later died from cyanosis. Evidently the *foramen ovale* had never closed. I will remark in closing that the sex of the atrophied fetus was male, that of the living baby, female.

Book Reviews.

All manuscripts for publication, and all books for review, in this journal should be sent to the Publication Office, 78 Maiden Lane, New York.

THE PATHOLOGY AND SURGICAL TREATMENT OF TUMORS. By N. SENN, M. D., Ph. D., LL. D., Professor of Practice of Surgery and Clinical Surgery, Rush Medical College; Professor of Surgery, Chicago Polyclinic, etc. Philadelphia: W. B. Saunders, 1895. 700 pp. cloth, \$6.00; one-half mor., \$7.00.

The subject of tumors, is, as the author says, one of the much-neglected departments of surgical pathology. In the craze for bacteriology all other departments of medicine have been neglected and but little advance, if any, has been made since the discovery of the alleged bacillus of consumption. We are glad to note that Professor Senn has escaped the microbic contagion and briefly disposes of the theory of the microbic origin of tumors by saying that it has not been established by any convincing experimental investigations or clinical observations. Based thus upon a solid foundation of fact we may therefore expect this exhaustive work to prove of great practical value alike to practitioner and the student, an expectation which examination shows to be well founded. Beginning with the origin and nature of tumors the first part of the work is devoted to a general con-

sideration of tumors, the anatomy, biology, and pathology of tumors, including those of plants and animals, passing onward to the consideration of their clinical aspects, diagnosis, prognosis, treatment, and classification, with full description of the various forms. The description of each class of tumors is followed by a consideration of the topographical distribution of that particular kind of tumor in the different regions and organs of the body, with a description of the different operative procedures for their removal. The style of the author is extremely attractive, easy, and clear, so that the reading is a pleasure ; the text is also profusely illustrated (515 engravings, a number being full page, colored) so that not only is the picture of the tumor described, kept constantly before the eye, but the method and technique of the more difficult operations is clearly pictured.

SAUNDERS' AMERICAN YEAR-BOOK OF MEDICINE AND SURGERY.
 Edited by GEORGE M. GOULD.

The important announcement is made by W. B. Saunders that early in 1896 he will commence the publication of the American Year-Book of Medicine and Surgery. It is the intention of the editor to review the contributions to American and foreign journals of the past year, condensing and epitomizing all that is new and valuable in current medical journalistic literature into a single volume, which will contain everything of value which has appeared during the previous year.

DISEASES OF THE RESPIRATORY PASSAGES. By CHARLES PORTER HART, M. D., author of "Nervous Diseases," "Nervous Therapeutics," etc., Late Professor of Neurology in Hahnemann Hospital College, San Francisco, etc. With 117 illustrations. Second edition, Rewritten and enlarged. New York: A. L. Chatterton & Co. Price, \$3.00.

This work, which is practically a *résumé* of the treatment adopted by the leading physicians of the homeopathic school in the commoner forms of diseases of the air passages, possesses a unique advantage for the general practitioner in giving in the clinical notes following the descriptions of the various diseases, excerpts from physicians of all shades of opinion, so that the reader can compare, analyze, and select the method of treatment which seems to promise the best results. The only fault we have

to find is that with some of the diseases the clinical notes are not sufficiently full and that the author has not given enough of his personal experience. What we want in our books nowadays is the experience of the author, what he has learned in his years of conflict with disease that makes him stronger and better equipped for the combat.

THE PRACTICE OF MEDICINE. By W. C. GOODNO, M. D., Professor of Practice of Medicine in the Hahnemann Medical College, Philadelphia. With sections on Diseases of the Nervous System, by CLARENCE BARTLETT, M. D., Vol. II. Philadelphia: Hahnemann Press, 1895.

The usefulness of a work upon the practice of medicine is to be judged by the knowledge of the cause, course, and symptoms of the various diseases which afflict humanity that the student can obtain from it, and by the help it affords the physician in the treatment of disease. Judged by these standards, the Practice of Medicine is a work of great merit and value. The descriptions of disease are full, complete, and clear, so that the student can learn diagnosis and prognosis, to make a clinical observation, without the aid of a microscope and scalpel; and the indications for treatment are concise and clear. If we have any fault to find it is that the therapeutic indications in some cases are not as thorough as Professor Goodno could have made them. His style is so good, his indications so clear, and his observation so true that we can only regret that so often he gives a *résumé* of treatment only. It is a work which every homeopathic physician should and doubtless will have. Vol II. treats of diseases of the circulatory, respiratory, urinary, and digestive systems, diseases of the blood and constitution, and parasitic diseases.

THE LONDON HOMEOPATHIC HOSPITAL REPORTS. Edited by GEORGE BURFORD, M. D., and BYRES MOIR, M. D. Vol. IV. London, 1894.

This is a paper-bound volume of 188 pages, containing a number of instructive and interesting papers upon different subjects by the members of the medical and surgical staff of the London Homeopathic Hospital. Among the valuable papers presented we notice, "Contributions on the Clinical and Therapeutic Aspects of Albuminuria," by J. G. Blackley, J. Roberson

Day, George Burford, C. Knox Shaw, and D. Dyce Brown; "Studies in Materia Medica: Anacardium," by D. Dyce Brown; "A Case of Pernicious Anæmia," by J. R. P. Lambert; and "On Some Uncommon Forms of Diseases of the Jaws," by Dudley Wright. The only fault we have to find with the book is that it is not bound in better accord with its value.

APPENDIX to DUNGLISON'S MEDICAL DICTIONARY. Philadelphia, Lea Brothers & Co., 1895.

The great addition of "words, words, words," which is constantly being made to the English language, and particularly of medical terms and phrases, is shown in this appendix to Dunglison's Dictionary, twenty-five pages of the size of the dictionary pages being necessary to contain them—whether these words are any addition is another question, but it seems we must have them. Dunglison with the appendix is up to date, and the end of the century dictionary.

PHYSICIANS' VISITING LIST FOR 1896. Lindsay & Blakiston.

This well-known visiting list presents several improvements in the new edition for 1896.

More space has been allowed for writing the names, and to the "memoranda page" a column has been added for the "amount" of the weekly visits, and a column for the "ledger page."

To do this without increasing the bulk or price, the reading matter and memoranda pages have been rearranged and simplified.

The lists for seventy-five patients and one hundred patients will also have special memoranda page as above, and hereafter will come in two volumes only, dated January to June, and July to December. While this makes a book better suited to the pocket, the chief advantage is that it does away with the risk of losing the accounts of a whole year, should the book be mislaid.

MANIKIN OF PELVIC AND GENITAL ANATOMY. Western Publishing House, Chicago, Ill.

This work comprises a series of finely executed plates and manikins, showing the details of structure of those organs upon whose unhealthy or abnormal condition, so much of the physical misery of humanity hangs, and affording means for such special instructive use in professional practice and treatment as the

peculiarly confidential relation between physician and patient demands and warrants.

Included in the work are charts illustrating elaborately and in the most life-like manner possible the entire anatomy of the generative organs (male and female). Every chart is just as perfect as art can make it ; and the parts, instead of being shown in an isolated form, are produced with almost marvelous accuracy in their relative positions, natural colors and comparative sizes, so they are seen just *as they are to be found in the living subject*, and so arranged that they can be lifted out, one at a time.

The parts are shown in the following systematic order :

(A) *Male Generative Organs.*

1. Surface or skin plate.
2. Scrotum, spermatic cord, seminal vesicles, etc.
3. Erective, vertical section of testicle, interior structure of bladder, etc.
4. Details of structure and physiological relations of all these parts.

(B) *Female Pelvic Organs.*

1. Exterior virgin structure.
2. Early symptoms of pregnancy.
3. Associated muscles, nerves, blood vessels, and glands.
4. Vagina.
5. Womb and its support (enfolded in peritoneum).
6. Ovaries, Fallopian tubes, etc.
7. Vertical section of all these organs.
8. Pregnancy after about six weeks.
9. After three months.
10. After five months, when organization is practically complete.
11. Pelvic receptacle back of generative organs.

(C) *Sectional View of Female.*

(Showing a vertical section from front to back, through middle of the female body, with a summary view of the organs within.)

(D) *Fetal Organization.*

MANUAL OF GYNECOLOGY. By HENRY T. BYFORD, M. D., Professor of Gynecology and Clinical Gynecology, College of Physicians and Surgeons of Chicago, etc. Cloth, \$2.50 ; pp. 448 ; 234 illustrations. Philadelphia : P. Blakiston, Son & Co., 1895.

This is a work intended for students, and for physicians who are not familiar with gynecological procedure, but who, not mak-

ing a specialty of this kind of work, still desire themselves to treat the cases which come into their hands, and is well adapted to that purpose. For the purpose of simplifying the subject, the author has made use of two styles of type, the essentials and the minor operation which the general practitioner may safely perform are put in large type, and the unusual and complicated ones are put in small type, thus emphasizing the difference. Treatment, and the technique of the various operations, are clearly described, and particular attention is given to details, and the student and general practitioner will find the book of great practical value.

PREGNANCY, LABOR, AND THE PUERPERAL STATE. By **EGBERT H. GRANDIN, M. D.**, Consulting Surgeon to the New York Maternity Hospital; Consulting Gynecologist to the French Hospital, New York, etc.; and **GEORGE W. JARMAN, M. D.**, Obstetric Surgeon to the New York Maternity Hospital; Gynecologist to the Cancer Hospital New York, etc. Illustrated with forty-one (41) Original, Full-page, Photographic Plates from Nature. Royal octavo, pp. viii + 261. Cloth, \$2.50 net. Philadelphia: The F. A. Davis Co., Publishers, 1914 and 1916 Cherry Street.

A noticeable feature of this work is the photographic illustrations of the actual conditions occurring during pregnancy and labor, and which are reproduced with fidelity to nature without any attempts at artistic effects, and which of themselves are worth a volume of text. Judging from some of the pictures the obstetrician represented was blessed or otherwise with a retinue of assistants. The work presents obstetrical art and science as it is taught to-day and is exemplified in hospital and maternity practice, and is intended as a working book for the practitioner; anatomical, embryological, and pathological data being omitted except when essential to a clear understanding of the text, only the information and instruction which is of practical benefit to the practitioner being given.

THE INTERNATIONAL MEDICAL ANNUAL. A Complete Work of Reference for Medical Practitioners.

E. B. Treat announces that this volume for 1896 is well under way and will appear early in the year. It will contain a Review of Therapeutics for the year, together with descriptive articles

on the New Remedies with clinical indications for their use; a dictionary of New Treatment, giving a complete index of diseases and showing the latest methods of treatment, both medical and surgical, in a series of specially prepared articles and reviews. The present edition promises to surpass in wealth of material any of its predecessors. The volume is copiously illustrated by colored plates and photographic reproductions in black and white. Price, \$2.75.

Materia Medica.

Coffea in Obstetric Practice.—Dr. Kallenberg.—Erethismic condition; anxiety and restlessness; cannot bear the pains; sparkling eyes; frequent, weak pulse.

Borax in Membranous Dysmenorrhea.—Dr. W. A. Dewey, Med. Cent.—Gripping pains from the stomach to the intestines. Menses are early and profuse, and there is much nausea.

Belladonna in Enuresis.—Dr. C. H. Evans, Clinique.—Belladonna is indicated when there is incontinence of urine days as well as nights; it is noticeable that such children moan and toss about during sleep, and occasionally their muscles twitch.

Aletris Farinosa in Amenorrhœa.—Dr. H. Minton.—Suppression of the menses resulting from atony of the uterus or ovaries. Great general debility. Weariness of body and mind. Heaviness in the uterine region. Distention of the abdomen, with bearing down pains.

Chamomilla in Leucorrhœa.—Dr. C. L. McElwee.—Yellowish, watery, smarting discharge; vagina feels raw, as if internally excoriated; aggravated after a meal. The pains make her almost furious and she will snap the head off her best friend when in pain. Cannot speak a pleasant word or give a civil answer when ordinarily "off."

Cicuta Virosa in Infantile Convulsions.—Dr. W. M. Butler, Med. Rec.—Head bent to one side, jerking and twitching of head. Spasms of all muscles. Convulsions, with loss of consciousness;

frightful distortions of the limbs and whole body ; head turned backward, body bent as in opisthotonos. Cramplike stiffness of the whole body with coldness. Lies as if dead, with clenched jaws ; staring ; stares with unaltered look at one place and cannot help it.

Causticum in Coccygodynia.—Dr. C. S. Elliott, Med. Aron.—Causticum is one of the chief remedies in diseases of tendinous tissues and in neuralgias. It is indicated where there is a dull drawing pain in the region of the coccyx ; pains as from bruises or darting pains in the coccyx ; every movement in the body gives a pain in the small of the back ; pinching, crampy pain in the lumbar region and buttocks ; painful stiffness of the back and sacrum, especially when rising from a chair.

Gelsemium in Hysteria.—Dr. C. E. Fisher.—Gelsemium is suited to hysterical epilepsy, convulsions with spasms of the glottis followed by stupor, languor, and physical prostration ; hysterical attacks in young girls who are subjects of nervous headaches that commence in the cervical portion of the spine and spread over the whole head ; the epileptiform spasms in association with dysmenorrhea, the head being drawn backward on the shoulders and the patient left so languid and debilitated as to be days in recovering.

Aconitum in Labor.—Dr. Yingling.—The vulva, vagina, and os are dry, tender, undilatable : the parts feel contracted and rigid. Great distress, moaning, and restlessness with each pain (or after). She fears she will not be delivered, or that she will die, or that something will certainly go wrong. Cessation of the pain when the cause is akin to fright. Spasmodic contraction of the os, with heat and dryness. Intolerant of examination from local sensitiveness. Fainting. Full of anxiety and fear. Pains unnaturally violent and frequent ; complains that she cannot breathe or bear the pains ; hot sweat all over ; contraction insufficient.

Agaricus in Chorea.—Dr. H. Chandler, S. J. of Hom.—From the study of agaricus made by the Medical Investigation Club of Baltimore, based upon thirty-one provers, we note that the principal action of the drug is upon the nervous system. The cerebral

excitement in many instances simulates delirium ; but in other provings the exaggerated and irregular muscular movements partake more of the spasmodic character found in chorea, and the twitchings which involve the muscles of head, face, and limbs, accompanied by pains of various kinds, palpitation of the heart, mental irritability, and restless sleep would naturally suggest agaricus as a probably useful remedy for this disease.

Calcareæ in Diseases of Women.—Dr. J. T. Kent, Med. Ad.—Calcareæ has a abundance of symptoms in relation to the woman. The woman who is tired and worn out with her housework ; the woman who is fatigued and exhausted from sexual contact with her husband, suffers from a copious milky leucorrhœa ; and the pelvic organs seems to be tender on pressure, sore to pressure, sensitive to pressure, full of pain, pain at the menstrual period, copious milky leucorrhœa, offensive leucorrhœa, an excoriating leucorrhœa, causing much itching, especially in women who are pale, who are waxy, a greenish waxy, looking like a wax figure, who are fleshy and flabby, have no ability to exercise, or even to think, always tired from physical or mental exertion, always have cold, damp stockings, and sweat about the neck and head.

Obstetrics.

Endometritis in Pregnancy.—Dr. Veit (Zeitschrift f. Geburtshilfe u. Gynak.) discusses the question of endometritis in pregnancy, a source of many troubles to fetus and mother. He continues Emanuel's researches and dwells on the fact that bacteria are found in the diseased endometrium in pregnancy. This probably indicates that endometritis existed before the pregnancy ; indeed, it was observed that bacteria existed in the same case in two pregnancies. In Emanuel's case of hydatiform mole microbes were also discovered. This change in the chorion is, both the observers believe, a result of endometritis in pregnancy, a disease which of itself interferes greatly with the development of the fetus to the last. When a hydatiform mole has developed, it

may be discharged and no further ill-result ensue. In other cases a few vesicles left behind may undergo malignant changes, and perforate the uterine wall. This latter result probably means that the primary endometritis was severe, so that the uterine tissues cannot resist the growth of the mole.

Suppuration of Corpus Luteum in Ovarian Abscess.—Dr. Langer (Prager med. Wochenschrift) carefully examined four specimens of undoubted abscess of the ovary. He found that the abscess wall was lined with cells bearing all the characters of those of the membrana granulosa in the degenerative stage, when the corpus luteum is developed. In a fifth the same condition seemed very probable, though not quite so certain. He believes that this kind of abscess is caused by direct suppuration of a corpus luteum; it is not the result of suppuration of a corpus luteum cyst, which is itself a pathological condition. He is still investigating this subject, for, according to the above researches, abscess of the ovary would seem to be a primary disease associated with menstruation or pregnancy.

Post-Partum Hemorrhage.—Charlotte Med. Jour.—In cases where all the ordinary means to check the hemorrhage have failed, swabbing the interior of the uterus with strong perchloride of iron has long been looked on as the last resource, but for cases of this desperate nature, plugging the uterus with antiseptic gauze is preferable. A pair of long uterine dressing forceps may be used to tuck in the gauze, and the procedure is facilitated by drawing down the uterus, and by seizing the anterior lip with a volsella. In a case of uncontrollable hemorrhage after a miscarriage, use dry carbolyzed gauze sprinkled freely with iodoform. The plug should be removed in twenty-four hours, and the uterus washed out with an antiseptic solution. The plug seems to act not only mechanically, but also as a stimulant to uterine contraction. Anyone who contemplates adopting this treatment should be provided with a plentiful supply of the gauze. Not only has the uterus to be filled, but the vagina must be firmly packed also, and the plugs kept in place by means of a T bandage.

Edema and Prolapse of Cervix in Pregnancy and Labor.—Dr. Geyl (Volkmann's klin. Vorträge) describes a second case of this rare condition. Five have already been collected by

Guéniot, the discoverer of the disorder in question, and one by Misrachi, and thus eight cases complete the series. Geyl makes use of the formidable name "*œdema acutum cervicis uteri gravidæ parturientis seu puerperalis intermittens.*" In his latest case he first saw the patient on February 19, 1894. She was in the seventh month of pregnancy, and complained that a body frequently protruded from the vulva and went up again. A sanious mucous discharge ran from it as long as it was down. A year previously Geyl had used the curette for endometritis. He had opportunities of examining the prolapsed body. It was a cylindrical structure, $2\frac{1}{2}$ inches long outside the vulvar cleft, ending in a blunt extremity nearly 2 inches wide. It pitted on pressure of the finger, the depression disappearing directly the finger was removed. On careful exploration it was found to be the anterior lip of the cervix. The chief examination was made on March 24, when labor pains were suspected. After rest, with elevation of the pelvis, the swelling disappeared. It came down again daily before labor. On the night of April 7 precipitate labor occurred, the child being delivered after four pains only, when the patient had been one hour in bed; the placenta soon followed. He arrived when all was over; the uterus was perfectly normal. Ten days later the anterior lip of the cervix felt simply a little larger than the posterior. As reduction is usually spontaneous, and as this case shows that labor is but little affected, œdema of the anterior lip is hardly a dangerous complication of pregnancy. It presents, however, a formidable appearance, and therefore obstetricians should be aware of its true nature.

On Delivery in Certain Cases of Impaction of the Trunk of the Fetus.—Dr. H. S. Spencer, Brit. Med. Jour.—In cases of head presentation it is sometimes found that it is impossible to deliver the child's body unmutilated after the head has been born, especially through a contracted pelvis. Apart from the rare cases of double monster and of tumors external to the child's trunk, the difficulty may be due to the large size of the child.

With a normal pelvis the obstruction formed by the child's trunk may be due to pathological conditions either in the serous cavities or the viscera. Diseases enlarging the thorax to any considerable extent is very rare. A slight serous or bloody

effusion in the pleura is very common, and I have once met with acute pericarditis in a newborn child ; but these effusions very rarely enlarge the thorax sufficiently to cause obstruction in labor. The trouble will almost always be found in the abdomen.

One of the most common causes of obstruction is distention of the child's belly with the gases of putrefaction—a somewhat rare occurrence even in fetuses which have been dead some time. It is, however, a good rule in all cases of obstructed labor to percuss the uterine tumor ; a tympanitic note will indicate the cause of the obstruction. Another not infrequent source of distention is ascites or peritonitis, by which sometimes the belly is distended to an enormous size. I have seen the vagina distended sufficiently to form an abdominal tumor, and great distention of the bladder and uterus has been met with by other observers : but the only other causes of obstruction which I have personally met with have been distention of the colon by meconium in cases of imperforate anus, cystic kidneys, hydronephrosis, and distended uterus, and enlargement of the liver and spleen in syphilitic children. The diagnosis of the cause of the obstruction can usually only be made by careful exploration under anæsthesia. The question of treatment then arises. Traction upon the child's head in order to deliver the trunk should be made with caution and judgment ; the employment of great force has caused rupture of the uterus.

If judicious traction fails to bring down the trunk it may be necessary to reduce the width of the child's shoulders. With this object I have found it a useful plan to snip through the clavicles with the scissors ; then, if necessary, to pass a blunt hook into the axilla, and thus bring down the arms. If delivery is still impossible it may be necessary to remove the head in order to gain room for further manipulations ; but before decapitating, it is advisable to seize the neck with a strong volsella furnished with interlocking teeth, which will prevent the trunk from receding out of reach. Usually not much advantage is gained by opening the thorax, and the broken ribs are troublesome. The hand should be passed up to the abdomen, which should be opened with the scissors or the perforator, if the obstruction is due to gas or liquid effusion, the obstruction is immediately relieved and delivery effected ; in other cases it may be necessary to remove the abdominal viscera.

And now to speak of a second class of cases. In transverse presentations it is rarely that version cannot be performed, and in impacted transverse presentation it is very rarely that decapitation is impossible. It has twice happened to me to meet with cases in which neither operation was possible. In both instances the pelvis was contracted and the soft parts œdematous, and in one there was the complication of placenta prævia. The uterus was retracted and as hard as a board ; the back of the child presented ; it was impossible to introduce the hand far enough to perform version or decapitation. I have never in midwifery met with such an *impasse* as these two cases presented, and the fact that Cæsarean section has more than once been performed for this state of affairs is an indication of the difficulty that has been experienced by others. It is in the belief that the method which I successfully adopted in these two cases meets the difficulty that I place before you the following method of treatment :

Make an incision through the skin of the child's back, and cut through its spine with scissors ; then apply Braxton Hicks' cephalotribe (the points of which meet when the instrument is closed) to the sides of the trunk of the child and screw up the instrument. By making traction with the cephalotribe the soft parts are brought down, and may be cut through with scissors. The delivery of the two halves of the child's body then presents no special difficulty.

Thrombus of Vagina in Pregnancy.—Dr. Queirel, *Annales de Gynéc. et d'Obstét.*—A primipara, aged nineteen, when in the eighth month of pregnancy, was seized with pain after violent coitus, and a swelling rapidly developed and bulged out of the vulva. It formed a purple pyriform body four inches long and nearly two inches wide at its broadest part. It was evidently about to slough. Forceps were applied to the pedicle, and it was cut flush with the forceps, and four sutures passed through the pedicle behind the forceps. The instrument being relaxed, the sutures were tied ; suddenly hemorrhage occurred as the last was being tightened. The mucous membrane was to be ligatured around the bleeding point. The patient was afterward delivered at term, labor being spontaneous and perfectly normal. This is the seventh case of thrombus of the vagina in pregnancy recorded in medical literature. In one (Auvard's) the thrombus was

already sloughy when removed. The patient, as in all the other cases, recovered. The chief importance of thrombus of the vagina in pregnancy is this tendency to slough, which sets up an essentially dangerous complication. Fortunately, removal of the thrombus and disinfection of the genital tract are easily effected.

Hypertrophy of the Cervix.—Dr. Thomson (Centralbl. f. Gynäk.) believes that this condition is congenital rather than inflammatory; at least, in all cases where the increase in length is extreme, the so-called “tapiroid cervix,” Küstner has observed it in the newborn infant. The rarity goes against the theory that it is due to any kind of sexual abuse or to injury during labor. He describes a very marked case. The patient was twenty-five and apparently a virgin. She had felt bearing-down pains in the pelvis for ten years. About six years before she first noticed something projecting from the vulva, especially after a walk. The period was regular, free, and painless. The diseased, or, rather, abnormal, cervix, gave a little trouble when walking or standing, but the patient was subject to obstinate constipation, and this accounted for much of the inconvenience of which she complained. When the patient lay down the cervix projected over three inches beyond the vulva. The os externum was of the normal virgin type. The sound passed over five inches till it stopped at the os internum. The supravaginal portion of the cervix seemed of normal length; the uterus was small, retroflexed, and somewhat low in the pelvis. The hymen was not torn, but extremely stretched. The cervix was amputated by the bloodless method; the sutures were removed on the twelfth day; the uterus and stump of the cervix then measured a little over $2\frac{1}{2}$ inches. The abnormal amputated structure showed no sign of inflammation, though it was œdematous.

Pregnancy at the Age of Fifty-nine.—With the ending of the century we observe many strange and startling events, such as earthquakes, cyclones, strange heavenly movements, late summers, and many other things out of the usual order of things in this country. Woman, ever ready to move along with the progressive world, give birth to a boy, full term, at the age of fifty-nine. A woman with snowy hair nursing a fine boy!

In the *Gazette de Gynecologie*, Dr. Depasse reports the case of an aged-looking lady with white hair, supposed to be suffering from a large uterine fibroid, whom careful examination proved to be pregnant. She was delivered of a boy at the full term, and was able to nurse him; she weaned her son on her sixtieth birthday. She had a married daughter aged forty. The age was verified by a certificate of birth.

Pain During Pregnancy.—In case of pain in either iliac region in a woman during pregnancy, ectopic gestation is to be suspected.

Pregnancy with Unruptured Hymen.—Guerard (Centralbl. f. Gynäk.) relates three new cases of pregnancy in which the hymen was persistent. In the first and second there was a protracted second stage due to the resistance of the hymen, which was perfect and very elastic. After a crucial incision the fetus was at once delivered, but in one case the child was lost. In the third case the patient appeared to be in the seventh month of her first pregnancy and suffered from severe pain in the genital tract. Although she had twice been operated on for atresia of the hymen, the vagina was still closed by a firm, impermeable, and tender membrane. This was excised, the pains disappeared, and pregnancy continued and ended naturally. Guerard notes a case of bifenestrated hymen where the openings barely admitted a hair; yet the patient reached the third month of pregnancy, and abortion was induced in a manner which could not be ascertained. In considering these cases, he notes how the alkaline uterine mucus, poured out during orgasm, protects the spermatozoa from destruction by vaginal mucus.

Manifold Pregnancy.—According to G. Veit, there occurs among about ninety births one case of twins, and among about eight thousand one case of triplets.

Their origin is due either to the fact that several ova (they may originate from one or two follicles; the latter may, as the corpora lutea proves, lie in the same, or one in each of the ovaries); are expelled during one menstruation, and are (eventually by different cohabitations) fecundated, or that the fecundated ovum contains several germinal nuclei.

Peri and Para-Metritis.—In the *Centralblatt für Gynäkologie* a compilation has been made from forty-three cases of all those inflammatory processes of the uterus and its appendages which so frequently result from childbirth, abortion, or gonorrhea. Several cases of salpingitis may have been included on account of difficulty of diagnosis. In old exudates a mere puncture was generally sufficient; in acute processes with rapid collection of pus a more extended incision, many times also drainage. Of the forty-four cases thirty-four recovered, nine were improved and one died of tuberculosis of uterus and peritonitis, twenty-three were incised, nineteen punctured, and twice there was spontaneous rupture into the vagina. The contents were generally pus, at times a bloody serum or clear serum. The quantity varied from one c.c to one liter. Length of treatment four days to five months.

Forceps and Facial Paralysis in an Infant.—Dr. Laskine (*Progrès Méd.*) speaks of an instrumental labor where the mother was a primipara, aged twenty-two. After she had been in labor for fifty-four hours the forceps were applied. A large child, weighing nearly ten pounds four ounces, was delivered; the perineum was torn. The child had facial paralysis, which was treated by the interrupted current. At the end of two months the condition had disappeared. Laskine admitted that the child's father had syphilis. Altogether, however, he thought the evidence was in favor of the opinion that the paralysis was caused by injury with the forceps. This complication, he thought, took long to cure. Gaulard, in a discussion on the case, knew of another far more chronic instance of the same lesion, for one of his colleagues, about forty years old, still suffered from facial palsy caused by the forceps when he was brought into the world.

Death from and after Post-partum Hemorrhage.—Dr Tarnier, *Jour. des Sages Femmes*.—Flooding after the application of the forceps must always be expected, since the instrument is usually employed because of uterine inertia, a source of hemorrhage. The danger comes when the placenta is expelled. When called to apply the forceps for a colleague in private, he used to leave before the delivery of the placenta. In consequence he

was very often called back. He makes these observations in respect to a robust woman who suffered from uterine inertia, and was delivered by forceps. There was considerable flooding, but not so much as to lead to expectation of bad results. The patient went to sleep, but awoke a few hours later and complained that that she was suffocating. There had been fresh hemorrhage. She very soon died. At the *post-mortem* examination miliary tubercle was found disseminated in abundance over the lungs, pleura, liver, and spleen. There was no evidence of insufficient blood in the system, no embolism, and no blood retained in the uterine cavity. The previous flooding, quite insufficient to harm a sound constitution, proved enough to kill this patient. Yet externally she looked healthy. We must be slow, says Tarnier, to find fault with a colleague for losing a patient after flooding. Had the above case occurred in private, and no necropsy held, the obstetrician would certainly have incurred more blame than he deserved.

The Tupelo Tent.—Dr. Penrose, Med. World.—The tupelo is the best tent. It should be placed in an envelope and heated to 250 degrees and allowed to remain sealed until wanted. Never use more than two in succession, and never insert them at the office and allow patient to travel with them *in situ*. The best method of dilating the cervix is by the dilators of Goodell.

Ætiology of Endometritis in Pregnancy.—The Wiener klinische Rundschau reported two cases of endometritis of the decidua, in which numerous diplococci were demonstrated in the decidua, at times plainly intracellular, but at that time no cultures were attempted. Recently one of these two patients again came under observation at the Polyclinic of Professor Veit. The decidua area was thickened to $2\frac{1}{2}$ to 3 cm., intensely yellow, and still remained *in situ*. Histologically the process appeared chiefly as a small-celled infiltration. Among these cells were found a multitude of bacilli, at times joined in longer strings, which were cultivated on agar-agar and gelatine. These bacilli are small rods rounded at both ends, and of moderate thickness; they show a great similarity to the bacterium coli commune, but are distinguished from it by their behavior under Gram's method. On account of the circumstance that the demonstration of these

micro-organisms occurred twice in the same patient, the writer believes that he can ascribe to them a prominent rôle in the ætiology of endometritis.

Indications for Versions.—Dr. Hirst.—

Shoulder presentations.

Deformity of pelvis.

Sudden accidents.

Malpositions of head.

Placenta prævia.

Prolapse of cord.

Contra-indications are :

High position of contracting ring.

Presenting part must not be engaged nor out of os uteri.

In applying forceps to the breech, remember not to clasp the handles tightly. Apply over the trochanters and avoid compression. The traction should be made from the shoulders of the instrument.

Glycerin Injections as an Oxytocic.—Pelzer (Centralbl. f. Gynäk.) has collected twenty-eight cases, including nineteen in his own experience. Glycerin was used eighteen times for induction of premature labor ; in fifteen of these cases the pelvis was narrowed, in two there was Bright's disease, and in one placenta prævia. To stimulate uterine action at term, glycerin was injected in seven cases of simple atony, in two of placenta prævia, and in one for some other complication. The pains came on after an average interval of two hours following the injection. Eight or ten hours elapsed before complete dilation of the os, or a longer space of time in cases of contracted pelvis. Two of the mothers died, both from severe eclampsia ; the fetus was putrid in both cases. One child required craniotomy on account of its great size. Three children died from placenta prævia and strangulation by the funis. One, hardly thirty-two weeks old died a quarter of an hour after birth. Only in one case could the violence of the pains be a possible cause of the death of the child. The glycerin had done its duty. Pelzer, however, deprecates injudicious zeal in this method ; one to two ounces, not four, are sufficient for injection. The method is not suitable for

cases of eclampsia and placenta prævia, except the lateral variety, where the placenta can be avoided.

Geuer read notes of three cases of induction of premature labor by injection of glycerin, in all of which both mother and child were saved. The first two mothers were over thirty-two, with contracted pelves ; craniotomy had been performed in previous labors. The third case was an instance of bad eclampsia ; 40 grams of glycerin were injected, the os being at the time uncontracted ; there was œdema, with much albuminuria. Forty hours later a healthy living child was born.

Child Crying in Utero.—In a case reported from San Francisco, the mother had been in labor for some hours ; the cervix was well dilated and the breech presenting. The natural forces seemed insufficient to effect delivery, and it was decided to perform extraction. Accordingly the mother was anæsthetized, the hand introduced and the foot brought down.

As soon as the foot appeared at the vulva the cry of a child was distinctly heard by all present. The sound was somewhat muffled and seemed as though it came from under the bed. The cry was repeated a number of times, but ceased as soon as the head engaged in the superior strait.

Delivery was effected as rapidly as was consistent with safety to mother and child. The latter was born asphyxiated, but soon revived, breathed, and cried again. There was no evidence of liquor amnii or mucus having been drawn into the air-passages. The child is now alive and well.

The explanation of this phenomenon is simple enough, for in the operation of bringing down the foot air entered the uterus and the child breathed, and was so enabled to utter the cries.

Dr. Grandin reported a somewhat similar case to the Obstetrical Society of New York. In that case version was performed, but in all other respects the case was similar to the one just reported. In the discussion that followed, four other members each reported a case, and an important feature in these four cases was that in two the child perished during delivery.

Another case of this kind was published in the Medical Press and Circular. In this case the vertex presented and the forceps was applied. It is stated that the crying continued until the

head was outside the vulva, which seems somewhat remarkable, as it is difficult to see how the child could cry while the head was passing through the pelvis.

In a medico-legal way this subject may be of some importance, since the fact that a child has breathed, when proved by post-mortem examination of the lungs, is considered proof positive that it had an independent extra-uterine existence. In the two cases that died during delivery this would certainly be an error, for had the lungs been examined evidence of respiration would have been found, and yet both were born dead.

Indian Women in Labor.—Dr. Guy C. M. Godfrey, M. D., Medical Record.—Owing to the reticence of the Indians in all matters pertaining to their childbirths, facts in reference to them are very difficult to obtain. The writer's experience has been with the Arapahoes and Shoshones in their agency, and he found that the women, owing to the hard labor they were accustomed to, were physically stronger than the men. The women are very industrious, and do nearly all the manual labor about their villages; they are very filthy in their habits, and by some it is claimed that virtue is unknown among them. The girls begin to menstruate when twelve or thirteen years of age, and continue until they are forty or forty-five, and are very regular. Menstrual disorders are almost unknown among the pure breeds. Their child-bearing period is between thirteen and forty-five years of age, the average number of children per woman being about ten or twelve. The squaws are quite healthy, scrofula being the most common disease among them. During pregnancy the women do not suffer from morning sickness, or constipation, or any of the ordinary disturbances to which civilized women are subject.

When labor begins, the woman lies in a semi-recumbent position, with a wedge-shaped bundle of sticks covered with cloth or skin under her head. All the men are required to leave the tent, and the patient is attended by two or three old women. They have no regular midwives, and the white physicians are seldom applied to. The old women remove all the patient's clothing below the waist, and if the labor is at all protracted they knead the abdomen with their hands. If the labor is unusually difficult,

two of the women hold a stick about a foot from the ground and require the patient to lie across it, abdomen downward. These methods are all the old women resort to, and if they fail the medicine men are called in. The delivery, as a rule, is short and easy, seldom more than three or four hours, the patient suffering much less than white or negro women. Abnormal presentations and pelvic malformations are very rare, but one case of the former having been reported at the agency in six years. This was evidently a transverse presentation; it lasted four days, and despite the efforts of the old women and the medicine man, it terminated fatally. The Indians know nothing of artificial delivery, and consequently it is never attempted. Retention of the placenta is not unusual, and for this complication the white physician is often called in. The Indian treatment is limited to tying the cord to the woman's thigh to prevent it from slipping back.

Multiple pregnancy is unknown among full breeds. The duration of the puerperal state is usually but a few hours, at the end of which time the woman is about her usual vocation. Eclampsia is unknown, and puerperal septicæmia is very rare. Mammary abscesses are frequent, and are due to exposure and the filthy habits of the patients. The maternal mortality is very small, but two deaths having occurred during parturition, to the writer's knowledge, in six years. Fetal mortality is small; abortions are rare among the full breeds, but common among the half breeds.

Gynecological Etchings.

Treatment of Cancer of the Uterus.—About two years ago, Dr. Bernhart of Munich announced that he had obtained very favorable results from the treatment of inoperable cancers of the uterus by intraparenchymatous injections into the tumor of a six per cent. solution of salicylic acid in alcohol at 60°. This treatment has also been successfully employed by a Russian physician, Dr. F. Fafius, in seven cases of this disease, the results obtained being just as claimed by the inventor of the method. Like the latter, Dr. Fafius found that the metrorrhagia and fetid

discharge ceased the pain was relieved, the general condition improved, and the evolution of the disease was checked in a marked degree. Dr. Fafius employed at each operation from one to four cubic centimeters of the alcoholic solution of salicylic acid, divided into five or six injections, in various parts of the neoplasm.

Conservative Surgery on the Uterine Appendages.—Baldy, Annals of Gynecol. and Ped.—It would be folly to attempt to formulate any hard and fast rules for the treatment of this class of patients; each case must be settled on its own merits. But certain general propositions may not be out of place:

1. The vast majority of fallopian tubes, whose canals have been closed by pelvic inflammations, have been rendered useless for all time to come.

2. There is no way in which we can with any certainty distinguish those few cases in which the tube might again be rendered patulous, and in experimenting in this direction practice has clearly demonstrated that infinite harm may be done as against the little good.

3. It is always well to save healthy ovarian tissue for the sake of the continuance of menstruation and ovulation where this can safely be accomplished.

4. Uncomplicated small hematomata and hydrops folliculi do not, as a rule, give rise to distressing symptoms.

5. It is extremely probable that in the case of the vast majority of uncomplicated ovarian diseases upon which so-called conservative surgery has been used, the relief of symptoms has arisen not from the surgery, but from the enforced rest in bed, proper feeding, nursing, and removal from care and worry; the disease being general and not local.

6. Adhesions or prolapse do not necessarily necessitate removal of the uterine appendages.

Is a Tendency to Diphtheria an Inherited Condition?—Times and Reg.—Doubtless most physicians have observed, in epidemics of diphtheria, a tendency among certain families to contract the disease, while other families, seemingly to be equally exposed to the infectious element, exhibit remarkable immunity.

Now that the advent of horse serum, in the treatment of diphtheria, has rendered conscientious reports concerning the diagnosis more important, is it not well to inquire into the natural immunity the human system may exhibit when in contact with the infecting element of diphtheria?

We note the horse is not prone to suffer from diphtheria. Why? It is assumed that an agent exists in the blood of the horse which renders the diphtheria poison inert. Is this any the less true of blood in certain of the human species? In other words, we often see croup, spasmodic, membranous, and diphtheritic, running in certain families from generation to generation.

It will be noted that Revilliod, a French observer, has intimated that there exists a family predisposition to diphtheria, and that often it is found that this condition is dependent upon a family history of tuberculosis.

The Color of Milk.—Dr. Hirst.—In cases of malnutrition of infants, the color of the mother's milk is absolutely of no value in determining its quality. Rich milk may be very blue and poor milk is often yellowish.

On Some Symptoms which Simulate Disease of the Pelvic Organs in Women and their Treatment—A. Rabagliati, Brit. Med. Jour. —Women, single and married, mostly nulliparous, but sometimes multiparous, complain of lumbar, iliac and ilio-inguinal pains, achings through to the back. They are fatigued, tired, listless, often with headache. Better in bed, though not much; but pain returns when they get up. The pains are much worse during and after the menstrual periods.

In the kind of case supposed, with no gross coarse disease of the pelvic organs, vaginal examination reveals nothing more than, say, a slight displacement; os, cervix, uterus, broad ligaments, and appendages being otherwise normal. In some cases a pessary seems to have relieved by its support, in others to have done harm. On the whole, Boerhaave's phrase, "disease of a lax fiber" seems best to cover the laxness and want of tone which characterize the disease. In multiparæ the parts may be more swollen and lax, and there may be leucorrhœa, which, however, is often present also in the unmarried, though to a less extent.

Different doctors take different views and give different opinions regarding this condition. One calls it neurosis and says it is, "a nervous affection," another calls it neurasthenia, a third, hysteria, a fourth, perhaps, colic. The writer remembers two cases so diagnosed—not uterine colic, which is often present, but intestinal colic, which shows itself in wholly different symptoms. Another doctor diagnoses displacement, and still another, oöphoritis or salpingitis. After much suffering and failure of relief, the patient is often induced in the end to submit to what she at first resolutely put from her, viz., removal of the appendages. Except for grave disease, for example, as severe adhesive oöphoritis, salpingitis suppurativa, etc. (of course ovariectomy for large tumors is not at present in question), the writer feels strongly that oöphorectomy is an unjustifiable operation. It unsexes the women, and for the most parts fails to cure their disease. A better procedure is cutting down on the umbilicus, rawing its edges, removing, if necessary, a finger depression of peritoneum, and bringing the edges together. This operation does not mutilate or unsex, and sometimes cures. It has always a most marked and beneficial immediate effect on the symptoms. The writer believes, however, that, as a rule, neither operation is necessary, as the women can be cured without it. As to oöphorectomy, although he has never known death from it (which would indeed be unpardonable, as a result of operation for a disease never of itself fatal), still he has known long-continued suppuration from it and slow recovery. Also as a remote result he has known new miseries from pain arising about the wound, adhesions of the stump, and so on.

Proceeding with the examination of these women, the writer finds tenderness of the oblique muscles of the abdomen, of the recti muscles, of the umbilicus itself (usually excessive tenderness there), of the quadrati lumborum, of the sacro-iliac synchondroses in most cases, and also of the sacral origins of the glutei maximi muscles. These tendernesses are not, therefore, neurotic, as is commonly supposed, but are myotic or myositic rather. They explain, the writer suggests, the complaint made by these women, of being easily tired. The kind of pain also is an aching, such as is associated with trouble in muscles, rather

than numbness. tingling, or smarting, such as characterize nervous involvement. Further, when investigation is continued, it is found that other muscles besides those named are affected, for example, the solei and gastrocnemii, the vasti, both quadriceps extensors, glutei medii, erectores spinæ, latissimi dorsi, pectorales, teretes, sterno-mastoids, splenii, trapezii, etc., several other muscles being also named. Further than that, the writer points out that the sphincter vaginæ, the interior or pelvic face of the sacro-iliac-synchondroses, the obturator muscles and membranes, the gemelli and pyriformes muscles, etc., are all tender. He also shows that the pain caused by pressing the appendages is different from that elicited by squeezing the muscles, and says that he makes a point, in examining these women, of distinguishing these different kinds of pain.

The writer draws attention to this : Minor degrees of disease may exist in the appendages, for example, dilatation of the tubes due to salpingitis mitis ; or oöphoritis mitis may exist coincidently or simultaneously with these myositic tendernesses ; and yet the latter are by far the main or chief cause of the complaints and sufferings of the women. In this way, when the myositis has been dealt with, the women recover, even although the salpingitis or oöphoritis remain much as they were. Of course, treatment of the perimysitis exerts a beneficial influence on the salpingitis, etc., but the perimysitis is so much the more important affection, that the salpingo-oöphoritis can often be neglected. Nevertheless, it has hitherto been considered the main disease.

Discussing the nature of the myalgia from which these women suffer, he shows that it is rheumatic in character : (1) It often comes on in women who have had acute or subacute rheumatism ; (2) It not infrequently results in acute or subacute rheumatism ; (3) As rheumatism affects joints, so does this affection, a true joint, like the mandibular articulation, being invariably involved as well as the false sacro-iliac articulation, also the false joints of the sternum, and the sterno-costal articulations ; (4) In women suffering in this way, the tarso-metatarsal joints, the metatarso-phalangeal articulations, and the metacarpo-phalangeal joints are apt to be affected. These are admittedly rheumatic affections, and so is this. (5) In myalgia, as an acute rheumatism, changes

are apt occur in the heart. The only difference is that in this affection the changes are generally slow, in acute rheumatism, rapid; but in chronic and mild rheumatism the changes are slow also. As the result of his reasoning and study of the affection, Dr. Rabagliati names it "perimysitis rheumatica." He says there is often found coincidently perineuritis rheumatica, affecting, among others, the infraorbital and supraorbital nerves. The presence of tenderness over these and other nerves may have led to the general belief that the disease is a neurosis. But perhaps the main reason for this view has been that pains, which are very severe at one place and time, have quite disappeared when we next see the patient. But this transitory and evanescent character is, it must not be forgotten, well marked in acute rheumatism also, in which affection it is very striking how a joint which is swollen and painful one day may be quite well the next while another joint has become affected.

Along with perimysitis and perineuritis rheumatica is often found periostitis rheumatica, and even chondritis, which the writer believes to be rheumatica also.

The pain caused by an adherent inflamed ovary is quite distinguishable from the myalgic pain described, and besides, in oöphoritis we can make out congestion and more or less fixation.

As to causation, the main cause is improper feeding, chiefly the bread and tea which these women mainly live on. In any case it must be the same causes which induce other sorts of rheumatism. Most of the women, even when quite young, have lost their teeth, a calamity due to the same cause.

As to treatment, the writer recommends placing the patient on a liberal diet, counteracting the rheumatism by appropriate remedies and washing out the waste from the blood by hot water taken an hour before food three times a day.

Finally, he lays great stress on the value of bathing, followed by methodized exercises calculated to put into action the often disused and pained muscles, and gives an elaborate series of directions for auto-piostomyo-kinetics (or self-movement of muscles under pressure). This he much prefers to massage, which usually only implies kneading, rolling, etc., of the muscles,

and no active contraction and expansion of them by the patient's own volition.

Administering Chloroform.—Dr. D. J. Spotswood, Internal. Jour. of Surg.—Chloroform may be given as safely as ether, if the following rules are adhered to :

1. The stomach should contain no food, and a very small quantity of liquid.
2. Place the head a little lower than the trunk.
3. Have no tight clothing about the patient.
4. The anæsthetic should be chloroform seventy per cent., alcohol thirty per cent., by volume.
5. A hypodermic of morphine sulph. gr. $\frac{1}{4}$, and atropia sulph. gr. $\frac{1}{16}$, should be given a half hour before administering chloroform.
6. The first inhalation of the vapor should be well-diluted with air, and very gradually given.
7. A teaspoonful of aromatic spirits of ammonia should be given in a half ounce of whisky or brandy by the stomach.
8. A starched towel folded in the shape of a cone, the apex open, should be used in administering the chloroform ; this allows the air to enter freely.
9. The pulse and reflex of the eye should be closely watched, and the towel cone removed from time to time when indicated.

Constitutional Treatment of Disease of the Female Sexual Organs.—Dr. W. R. Kirk, Gross. Med. Bull.—Disorders of the female sexual organs are no exception to the universal rule that all local diseases, whether organic or functional are largely under the control of general systemic medication. This simple truth in the present operative era of gynecology is often overlooked in the mad desire to establish brilliant surgical statistics, and unwarrantable invasion, for the relief of local conditions, is often practiced in the name of science when the cause is far remote, as is generally evidenced by the failure to relieve the symptoms.

Using the Sound.—Dr. Penrose, Med. World.—Never pass the sound as a routine practice. Always have a definite object in view that can be attained in no other way. Refuse to pass it

if patient admits missing a monthly period. Never pass it in cervical cancer. Never pass it during menstruation. A useful substitute is the whalebone probe of Thomas. It has the advantage of safety from perforation of the uterine wall.

Self-injury in Hysteria.—Dr. Krecke, Münch. med. Woch. —Injuries are self-inflicted either on account of anticipated advantages or owing to abnormal mental states. The injuries inflicted on themselves by the hysterical are mostly of a chronic character. In one case the injuries were chiefly on the arms, legs, and face. Various forms of lesions were noted—reddening, blisters, old crusts, ulcers, and scars. These were made by means of a caustic alkali. These patients almost always present signs of hysteria. The author thinks that his patient first inflicted these injuries as the result of some imperative idea, and that later the comfortable hospital life played an important part in the ætiology. The patient also suffered from mania operatoria. In the simplest cases the injuries are inflicted by means of friction with the nails and ends of the finger, then by rubbing the bandage backward and forward, and lastly by a chemical agent. The question of diagnosis is important; the condition, if suspected, is generally recognized.

Hydrorrhœa Gravidarum.—S. Chazan, Centralb. für Gyn.—Three principal sources of the fluid which escapes from the uterus during pregnancy are: the uterine wall, the space between the fetal membranes, and the sac of the amnion. Hennig and Schroeder believe that the fluid collects between the chorion and the decidua, while Kaltenbach and others consider that it lies between the opposed surfaces of the decidua vera and reflexa. The fact that the escape of fluid often begins in the third or fourth month, at a time when, under normal conditions, the two decidua have not united, supports the views of Kaltenbach. In the early period of pregnancy a space is found to exist between the decidua vera and decidua reflexa, which ordinarily contains only a little mucus, but which might become distended with fluid by hypersecretion from the decidua, or by hemorrhage. In recorded cases there has been no direct evidence produced that union had not taken place between the decidua vera and decidua

reflexa ; but this seems to be the probable explanation of the fact that the greatly thickened vera has been sometimes separately expelled after the placenta.

The nature of the pathological process which causes decidual hydrorrhœa is still obscure. Braun emphasizes the existence of previous endometritis with exudation. Hegar considers the morbid process to be of the nature of hypertrophy of the decidua, especially of its glands. Scanzoni believes it to be due to transudation dependent upon the condition of the blood. Zini regards the fluid as an extravasation resulting from the hyperæmia, and increased vascularity of the uterine mucosa. Chazan himself is inclined to refer it to the periodic congestion of the genital organs, which occurs during pregnancy.

Duges and Jörg indicate the allantois as a possible source of the fluid in hydrorrhœa. It is well known that in many instances the amnion and chorion, instead of being glued together by an amorphous tissue, are separated by a collection of fluid, so that two sacs are present in the afterbirth. It may be that these so-called forewaters can escape during pregnancy, and thus explain some cases of hydrorrhœa, but this cannot be proved, because we know no sign by which these waters may be distinguished. Döderlein has proved that in a case observed by him, the forewaters could not be chemically distinguished from the liquor amnii.

There still remains that form of hydrorrhœa in which the liquor amnii escapes during pregnancy. Chazan records the case of a primipara, aged twenty-three, who consulted him, when five months pregnant, for thirst, weakness, and dyspnœa. He diagnosed hydramnion from the large size of the uterus. About the end of the sixth month labor pains set in, and abortion seemed about to occur. After the pains had lasted for some hours, however, a large quantity of watery fluid escaped, and the pains then gradually ceased. Fourteen days later a second escape of fluid occurred, preceded by pains of similar character to the first. The patient then went without any further loss of fluid to term, when a normal labor occurred, the child being strong and well-developed. The afterbirth was carefully examined, the chorion was found to be separated from the amnion over a wide area ;

besides the opening through which the fetus had passed, a second aperture, as large as a sixpence, with slightly thickened edges, was found in the amnion in the separated area.

Extension of Gonorrhea from Vulva to Rectum.—Dr. Hartmann, Ann. de Gynec. et d'Obstet.—The discharge from the vulva may undoubtedly set up gonorrhea in the anus or rectum in careless subjects. Direct transference may occur in obvious ways: thus, a constipated patient, accustomed to pass the finger into the rectum to facilitate defecation, conveyed the gonorrheal poison to the lower bowel. In another case extension was evidently solely due to the passive flow of discharge out of the vulva on to the anus. A patient, aged seventeen, was admitted on March 15, 1894, with gonorrhea of a fortnight's duration. A large drop of muco-pus hung from the vulva. A fortnight later the patient complained of pain in the anus, which bled a little. On April 7 a fissure had developed close to the hypertrophied fold; on the 24th the vulvo-vaginal glands were found inflamed. On May 14 there was much erythema around the anus; anteriorly a small condyloma masked a deep, wide, bleeding fissure, which gave the patient extreme pain. The secretion of the urethral canal contained gonococci. In June the pains ceased, and the patient seemed in good health. In July no more gonococci could be found in the urethral pus, but the anal pus was full of that germ. On October 15 the anal fissure remained, hidden as before by a condyloma; it was markedly indolent, and did not extend into the rectum, which was healthy. The pus on the surface of the fissure was full of gonococci.

Pediatrics.

Acute Tonsillitis.—Dr. Massei (Rif. Med.) notes the clinical differences between the various forms of membranous angina. In the first place if the patient cannot open the mouth you may

almost invariably exclude diphtheria, and suspect one of the inflammatory non-diphtheritic forms of angina. If the affection is a single manifestation, without any erythematous or papular eruption, suspect diphtheria; if on the second, third, or fourth day of scarlet fever, the angina is probably coccogenic and not bacillary. In presence of a yellowish white, easily separable membrane affecting chiefly the tonsil, one should suspect staphylococci alone or in conjunction with streptococci. If the exudation is thicker, more compact, grayish-white, and developed not only on the tonsil but on the uvula as well, or if the membrane is surrounded by a well-marked hyperemic zone, it is probably of streptococcal origin. If the exudation is very white, compact, and dense, it is probably due to pneumococci; if the pseudomembrane has the character of a compact, fixed, dense tissue, more or less thick, it is most likely due to staphylococci alone. These are, of course, only rough and ready clinical diagnoses, where bacteriological examination is not obtainable. Menstruation, dyspepsia, etc., and other so-called causes of tonsilitis, only act as way-openers for the ever ready microbe.

Periods of Isolation for Contagious Diseases of Childhood.—Dr. Olliver (*Gazette Medicale*) gives the following rules:

For scarlatina, variola, varioloid and diphtheria, the period of isolation, before the child is allowed to return to school, should be forty days, counting from the first day of invasion.

For measles and varicella, sixteen days will be sufficient.

For pertussis, isolation should be prolonged to three weeks after complete cessation of the characteristic kinks.

For mumps, ten days after the disappearance of the local symptoms.

Nasal, buccal, and pharyngeal irrigations with antiseptic solutions should be employed, and soap bath and rubbing of the entire surface and scalp should be a necessary preparation before returning to school.

Hydrogen Peroxide in Diphtheria.—The best local application in diphtheria is, doubtless, hydrozone, which possesses the

great advantages of being readily applied, in the case of smaller children, by spraying the nostrils and throat, of being not unpleasant and of being effective in disinfecting and deodorizing the discharge and preventing suppuration.

It is important to note in this connection that the peroxide should be reliable and of standard strength such as hydrozone, and not an inferior substitute. Owing to the fact that substitution is practiced to a great extent, we suggest that our readers report to us any case in which they have been the victims, giving the name and address of impostors, and all particulars and we will print in our columns the names of such fraudulent dealers.

Invagination of the Intestine in Infants.—M. Hirschprung had seen 64 cases of intussusception in children—46 in infants under one year, 36 were nurslings. In the 64, 38 recovered.

He divided this affection into that of the ileum, the ileo-cæcal, and colic. Ileo-cæcal is the most common. It comes on suddenly, and commonly disappears from twenty-four to forty-eight hours. When not spontaneously relieved the infant goes into collapse, the temperature falls, and the tumor appears in the right iliac fossa.

The most common age for intussusception of the colon is under the first year. The affection comes on slowly, being generally preceded by diarrhea or rectal tenesmus, and blood with mucus is freely passed. The most frequent seat is in the sigmoid flexure of the colon. Fecal vomiting is rare. Intussusception of the small intestine comes on brusquely, usually in infants over nine months old. Its cause is very obscure. Obstruction, it seems, is not complete in this type.

In order to accurately examine these cases, an anæsthetic should be given to relax the abdominal walls. When the symptoms are not too urgent in some, one may liberate the bowel by massage. Ileo-cecal invagination may be often overcome per enemata. When these fail, laparotomy offers the only hope; but to secure the fullest benefit we should not delay too long.

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EDITOR, B. F. UNDERWOOD, M. D.,
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AFFECTIONS OF THE VISUAL APPARATUS ATTENDANT UPON MATERNITY.

BY

CHARLES DEADY, M. D.,

Member of Board of Governing Surgeons, New York Ophthalmic Hospital.

IT is not remarkable in view of the many dangerous complications which are possible to every obstetrical patient, many of which threaten life itself, that visual disturbances should be relegated to a secondary position in the mind of the practitioner. Nevertheless, the annoying and sometimes serious results often obtaining from neglect or want of caution, furnish a sufficient reason for a brief survey of the field.

Every oculist of experience can readily call to mind instances in which the labor of months on a difficult case has been practically nullified by the intervention of pregnancy and its train of sequences.

The peculiarly hyperæsthetic condition of the pregnant woman renders her extremely susceptible to injurious influences, and that which might be safely undertaken at other times may easily become a source of danger under

the altered conditions. Again, the disturbances of circulation, the possible accidents and the not infrequent inflammatory and septic complications of the parturient state, all constitute factors of great importance in their influence upon the ocular functions.

Affections of the eye are not confined to any particular period of the process. They may occur among the earliest signs of pregnancy, as, for example, the striking pigmentation of the lids which is often seen, and which corresponds to the similar conditions encircling the nipples. They are common during gestation, occur during and as the result of labor, in childbed, and not infrequently during lactation.

In many patients some particular symptom or condition peculiar to the individual appears so constantly as to constitute a positive sign of conception. In rare instances this may take the form of ocular disturbance, as in the case related by Bloding, in which the appearance of strabismus in first one eye, then in both, was a sure indication of pregnancy. Other hysterical symptoms, as polyopia, a condition in which several images of an object are seen, may appear early and persist for a considerable period.

A special tendency to phlyctenular affections of the cornea and conjunctiva has also been noticed by authorities. Perhaps the commonest form of visual disturbance is asthenopia, or weakness of the muscular apparatus, and this may be confined to the ciliary muscle or to one or more pairs of the recti muscles, or may include both. In the first case, near vision is irksome and painful, because of the difficulty in accommodating for the proper distance. In the second, the troublesome symptoms are due to the inability to fix a given object for any length of time, the weakened muscles giving way and causing blurring and indistinctness.

Where patients have previously suffered from muscular anomalies, and have been relieved by proper treatment, relapses are almost certain to take place on the occurrence of pregnancy unless the greatest caution is exercised, and in these cases the eyes should be carefully guarded from the time of conception to the end of lactation, particularly

when the general system is reduced, as after severe vomiting, during the whole period of childbed, and especially where hemorrhage has occurred.

Passing from the simple affections mentioned, many of which are due to the peculiar sensitiveness incident to pregnancy, we take up those graver complications arising as the result of circulatory disorders. The disturbances of the renal functions, so familiar to the obstetrician, constitute an important factor in the origin of grave ocular lesions.

It is assumed that the educated physician keeps himself thoroughly informed respecting the condition of the kidneys of the pregnant woman, and while it is perhaps unusual that the ocular symptoms should afford the first indication of a derangement of these organs, cases do occur in which the presenting general conditions fail to give adequate warning of impending disaster, and here ophthalmology is sometimes able to offer valuable aid. As a general statement any disturbance of vision occurring during pregnancy should be rigorously followed up and its cause ascertained. Sometimes symptoms which might appear trifling to the novice portend the most serious results; thus, DeWecker relates a case in which a lady, in the seventh month of pregnancy, and apparently in perfect health, complained of slight dimness of vision, and upon the first examination only a slight haziness in the vicinity of the optic disk was found. At a second examination, held the next morning, a very small hemorrhage was discovered in the same situation. Her physicians were informed of the necessity for immediate interference, but deferred action until more urgent symptoms should present. Within forty-eight hours the patient died in convulsions.

As a result of albuminuria we may have hemorrhages, retinitis, detachment of the retina, and uræmic amaurosis, and the presence of any of these conditions should lead to the serious consideration of the advisability of inducing labor immediately, although even this is not always sufficient to save the patient's life. Occasionally, amaurosis

occurs during pregnancy from no apparent cause. Hosch (*Correspondenzblatt für Schweizer Aerzte*, Basle, March 15, 1891) reports a case of a woman in the sixth month of pregnancy, who awoke one morning blind. The pupils were fixed, there was no retinal hemorrhage, the optic disks were but slightly reddened, and there was no albumin in the urine. A few days later spontaneous labor took place, followed by a gradual improvement in sight.

Retinitis and uræmic amaurosis may not occur until labor has set in, or they may make their appearance in childbed. In albuminuria persisting during childbed, the presence of retinitis affects the prognosis unfavorably.

Affections of this character are most frequent in primipara, and where a woman has suffered in this manner during her first pregnancy, the lesion is apt to recur, and often in a graver form, in subsequent pregnancies.

It is well known that vision may be seriously affected by severe losses of fluid, and hence we may sometimes see amblyopia, and even amaurosis, from violent vomiting during pregnancy, the effect being due to the resulting anæmia.

Hemorrhages, whether from abortion or labor, are still more liable to bring about this condition.

Temporary amaurosis has also been observed as a result of jaundice. At the onset of labor, mydriasis or dilatation of the pupils occurs, and is due to spasm of the sympathetic.

Besides the conditions already enumerated as having their origin during pregnancy and persisting through the period of parturition, and which are mainly the result of renal disturbance, we have other forms of lesion which occur during or after labor, and which are due to causes peculiar to that function. Thus Knaggs, in London *Lancet*, April 7, 1894, reports a case of pulsating exophthalmus of the left side, following labor, and complicated with suppuration of the vitreous and of the orbital cellular tissue. The orbital suppuration ceased in one month and both eyeballs atrophied.

Optic neuritis has also been observed, probably due to hemorrhage into the optic nerve sheath.

Again, vision has been seriously impaired by cerebral hemorrhage, or this might result in any of the different varieties of motor paralysis, the effect upon the ocular functions being dependent upon the site of the hemorrhage. These conditions are clearly due to accidents occurring as the result of the violent exertions of the patient.

On the other hand, cases occur in which the visual disturbance is the result of irritation of the cortex from vascular spasm and consequent anæmia. In this class may be cited the case reported by Reuling, of gradual double blindness without lesion, shortly after a painful labor, with final complete recovery. Weber also reports a case of almost total blindness following a very painful labor, without eclampsia or albuminuria, recovery in one month.

Under this heading must also be placed two cases reported by Seguin. The first, of a woman who, after the birth of a child, had pain in the left temple and subsequently right hemianopsia. For a time there appeared in the blind field images of simple objects, as articles of furniture, etc. In the second case, the patient soon after parturition had pain in the head, and vision began to be blurred and indistinct. After a time the left field was lost, and soon visual images appeared in the blind region. The images were of cats and dogs and children, who arranged themselves in rows and formed processions, the children moving in circles, the animals remaining still. These phenomena continued for four weeks, the vividness of the images being increased by fatigue and headache.

We have already noted the fact that uterine hemorrhage may induce retinal complications, and we may here cite the cases reported by Beyer and McNaughton Jones. The first, recorded in the "Transactions of the German Gynecological Society," fifty-eighth meeting, being a case of anæmic retinal hemorrhages after difficult detachment of placenta, the second, "Transactions of London Obstet-

rical Society," vol. xxxii. p. 134, of central choroido-retinitis, the result of a *post-partum* hemorrhage. The disease appeared the third day after labor, there having been no previous visual defect. No albumin during or after pregnancy, no cardiac trouble. Vision in the right eye was normal; with the left eye the patient could only count fingers at five feet; the region of the macula lutea was punctated, with white dots; the macula was blurred and the dots extended toward the optic disk, which was pale. The disease was supposed to be due to choroidal thrombosis from hemorrhage, the irritation therefrom causing the retinitis.

Nettleship reports a case of failure of sight occurring after two successive confinements. The first time, vision in both eyes failed very shortly after labor, and remained bad for three weeks, with some occipital headache. Later perfect recovery ensued. In the second pregnancy, vision began to fail a week before labor, and one day before, the patient could scarcely see anything. There was no flooding and no other abnormal symptoms. This time the sight improved very little, being only $\frac{1}{100}$ four months later.

In childbed, visual integrity is threatened by fresh complications. As a result of the recent ordeal, the resisting power of the patient is frequently much reduced and hysterical symptoms may again present from slight causes. A case in point is reported by Szili, where sudden blindness occurred on the fourth day after labor from opening a window in a darkened room. The reaction of the pupil to accommodation was retained and the ophthalmoscope revealed a normal fundus. Vision was restored in six weeks.

In certain forms of puerperal fever septic retinitis may make its appearance, the infectious material being conveyed to the retina by means of the lymphatic channels along the coats of the vessels. Indeed, during both parturition and childbed, local and general infection may result from the absorption of decomposition products and

metastatic affections may develop in all organs, including the eye. In chronic infection, toward the end of life, extensive retinal hemorrhages may occur. Death takes place before they undergo much change. In other cases, embolic suppurations are caused in the eye, the choroid and retina being chiefly attacked. Septic embolism is followed by supuration and general panophthalmitis. Embolic panophthalmitis is most frequent during the second and third weeks of childbed, and is not infrequently bi-lateral. The prognosis is usually bad for both sight and life, although recovery occasionally takes place with the loss of one or both eyes. The optic nerves may also be the site of septic abscesses.

Snell, in the *British Medical Journal*, June 19, 1886, reports a case of embolism of the central artery of the retina, occurring as the result of the puerperal septicæmia, in a primipara aged twenty-six, sight being suddenly lost in the left eye. She recovered from the septicæmia but the eye remained blind, and the ophthalmoscope revealed the presence of an embolism.

Walter observed embolism of the central artery of the retina of the left eye, in phlegmasia alba dolens, on the fourth day of childbed.

Hemorrhages may also occur in all the vascular parts of the eye as the result of non-septic emboli following venous thrombosis.

During lactation a number of conditions may present as a result of the drain upon the system and the consequent anæmia and debility. Perhaps the simplest affection from this cause is œdema of the eyelids, which may be considerable in degree. Failure of the power of accommodation is not at all uncommon among nursing women, especially where lactation is prolonged and the patient has been originally delicate.

This condition is most common among young multipara, and particularly in hypermetropes. The loss of accommodation is seldom complete, but the patient is usually unable to read small print or to do fine work without assistance.

The iris is rarely affected, the pupils being usually equal, the visual acuity somewhat reduced, especially where hyperopia is present, and the fundus of the eye normal but anæmic. In other cases there may be no anomaly of refraction, but a certain amount of paresis of the ciliary muscle may exist, resembling that which occurs after diphtheria.

These patients are not subjects for glasses, except in so far as they may be necessary for the correction of pre-existing hyperopia. The proper treatment is to wean the child and correct the debility by a nourishing diet and appropriate medication.

Numerous cases of amaurosis are reported as occurring during lactation. Many times the blindness is temporary, normal vision being restored on removal of the cause. Nettleship (London Ophthalmic Hospital Reports, December, 1891) mentions a woman who became totally blind three months after childbirth, and remained so several weeks. The failure of sight was not sudden, and after weaning the baby it gradually returned and in three months the patient could see as well as ever. Sometimes, however, the issue is not so fortunate, and the ophthalmoscope may show congestion of the optic nerves, and even optic neuritis, to be followed by partial or total atrophy.

In all cases of visual defect resulting from lactation, the child should be weaned at once, and the general condition of the patient improved by every possible means.

It will be seen from the foregoing that the maternal function carries with it a liability to many and serious lesions of the visual organs, and too much care cannot be exercised for their prevention. Especially should patients be warned of the danger in using the eyes for any near work during the often tedious convalescence after confinement. Not infrequently, carelessness at this period results in months and even years of suffering, if nothing worse, and the physician should not only give positive orders respecting this matter, but he should, so far as lies in his power, see that they are obeyed.

ON SUB-INVOLUTION OF THE PUERPERAL
UTERUS: WITH REMARKS ON A NEW
THERAPEUTIC TREATMENT WITH SALTS
OF POTASSIUM AND GOLD.

BY

GEORGE BURFORD, M. D.

OF all forms of uterine trouble, none is so common as chronic enlargement; and of all causes of such uterine decadence, none is so usual as gestation.

Again: Of all chronic uterine conditions, none is so preventible as sub-involution; and of benignant uterine lesions few are so difficult to radically cure.

I propose to trace the natural history of sub-involution rather in its finer issues than its gross developments; and merely as a pathological basis for an adequate and effective treatment. I propose to indicate the steps by which the uterus passes from the early phases of defective repair to that hypertrophied, dilated, and indurated state known as chronic metritis. In this outline I have new views to present, new sequences to attest, and a new treatment to indicate; and for prolixity in detail I must plead the legitimate enthusiasm of the original worker.

In the Life-history of the Uterus, its Normal Function is that of Gestation; and its Quiescent Period that of a Resting Spore.

The specific function of the uterus is gestation; and the unique element in its life-history is that it can remain for indefinite periods as a dormant organ. The non-pregnant uterus is a quiescent structure, whose mass is maintained at a minimum; only so much tissue being retained as is

adequate to construct the pregnant organ, under the stimulating influence of conception.

We know how certain lowly organisms, when their activities are limited, will concentrate the essential units of their structure, disband all accessory elements, and remain quiescent and passive as resting spores. Later comes a cycle of activity, when rapid growth, active reproduction, and the miscellaneous evidences of renewed vitality present themselves, again to lapse into hebetude, awaiting the renewed incidence of the appropriate stimulus.

Just such is the life-history of the uterus; now like a fully equipped monad, assimilating and proliferating; and now like a resting spore, stripped of its mature increments, and reduced to the germinal elements of a later development.

Thus the essential feature of uterine physiology is that of alternating cycles, now of prolonged growth and activity, and now of prolonged latency and quiescence; and in this paper we deal with defective retrocession of the physical basis of the active cycle into that of the latent period.

After Childbirth the Uterus undergoes entire Re-creation.

Now the histology of the pregnant uterus is very different from that of the uterine organ in its functionless stage; thus, to note only the most marked sign of differentiation, the muscle fiber of the pregnant uterus is ten times as long and five times as thick as that of the quiescent period. Why the short muscle should be inadequate for the requirements of gestation is not clear. Large uterine fibroids and similar masses are composed of short muscle fibers.

Nature thus stamps the short muscle of the quiescent uterus as incompetent for the purposes of gestation, and a more highly differentiated tissue is specialized for the work. Gestation completed, the laws of physiological economics provide for the disintegration of this new mass

of specialized tissue, now functionless. The researches of Lionel Beale on formed and formative matter clearly contravene the notion that by some juggle part only of the specialized gestation tissue is absorbed, the remainder undergoing such an extraordinary transformation that individual muscle cells of the specialized type are watered down into cells of the quiescent type. Yet this is the astounding fiction taught in text books, which append a *reductio ad absurdum* in setting forth that the gradual absorption of functionless tissue constitutes a heavy stress on the forces of the organism!

Both physiological law and clinical experience lend color to the view that normally the whole mass of specialized gestation muscle necessarily disintegrates; that the rapidity of this disintegration is controlled chiefly by the ease with which ordinary muscle fiber can be generated to replace it; and that departures from this normal process are due to the defective genesis of new muscle and not to the too prolonged conservation of the old.

Aberrations are due to the Defective Genesis of New Muscular Tissue and not to Arrested Dissolution.

Sub-involution is the term given to aberrations from this normal course. Those who rely on parchment oracles still receive as true that sub-involution is practically an affair of the uterus. As well maintain that heart disease is merely an affair of the heart, or that gout is primarily an affection of the joints. Darwin has established the view that the incidence of changes due to civilized life is first and heaviest on the reproductive system. We must look beyond the mere local issue, and discern in sub-involution the outcome of a stream of tendency. We note that the routine of urban life encroaches far too much upon the margin of easy recuperation, reserved by nature for such special stress as that of the puerperal process. In this light it is more than ever difficult to conceive that defect-

ive involution is a matter of retarded disintegration ; that defective vital force can hinder retrograde changes in the gestation muscle ; that metamorphosis, fatty or other, is actually a tax on the vitality of the organism. On the other hand, this scheme I present to you is adequate to the facts :

That on the cessation of labor the gestation-muscle commences and continues to undergo degeneration and absorption.

That the tissue thus affected undergoes this change by virtue of the cessation of its function and the withdrawal of its special stimulus (that of gestation).

That degeneration of the old, and regeneration of the new tissues are simultaneous and reciprocal ; and that immature gestation-muscle probably matures as permanent tissue.

That the bulk of the sub-involved uterus is due to the rank luxuriance of the new growth—to the defective trophic control over proliferation, due to the altered balance of local circulation. In other words, the circulatory defect precedes and conditions the trophic defect.

These views further make lucid a clinical enigma which otherwise lacks solution. What is the factor which makes puerperal convalescence as tardy as that from acute disease ?

A gravida goes to term in the enjoyment of fair health ; the pains are mild, the hemorrhage inconsiderable, the fatigue of labor less than that of a day's tennis playing. The ensuing day finds the patient with no further demand upon her energies, if lactation be declined, and she rebels against confinement to bed. In a fortnight's time this same woman leaves bed with every sign of acute debility, and to regain the vigor of the *status quo ante partum* requires yet a full further month of circumspect supervision of routine. What element has been intercalated, since the delivery, to tax and task the vital energies ?

The clear enunciation of this problem indicates its own solution; for in physiology the constructive forces absorb energy, the destructive forces furnish it. Here is an inkling of the explanation; it is the reconstruction, the genesis of the uterine muscle with its new vessels and new nerves, and its co-ordination with the other bodily organs that absorbs the strength, that tells so much upon the vital forces, that requires for the time the full and undivided attention of the economy to its accomplishment. Its parallels are numerous and attesting; for wherever rapid reconstruction of tissue occurs, there also is for the time systemic debility.

On the Easy Derangement of the Regenerative Process.

The factors in the *post-partum* regeneration of the uterus are readily perturbed. It is the rapidity of the re-creation which is the disturbing element. The whole organ has to be renewed, so to speak, against time; and this at a juncture when active retrograde metamorphosis is carried on in the same place. Other factors contribute. For the formation of healthy tissue, an adequate supply of healthy blood is necessary; the venous and lymphatic circulations must remove all oxidation products; and the great emunctories of the body, chiefly the liver and kidneys, must be competent for the effective dealing with these. Now frequently the quantity of blood lost during parturition is not immaterial; its nutrient qualities are further impaired by portal congestion due to the necessary sedentary life, by the renal changes during pregnancy being scarcely yet rectified, by the limited oxidation of degeneration products which the liver can accomplish, by the necessarily limited dietary, and by the further demand, though normally healthy and desirable, of lactation. Any or all of these may limit the active constructive processes now going on in the uterus.

The Prime Factor is Vasomotor Derangement.

The first defect is a vasomotor defect. The uterine attribute of retraction has shut off the overplus of arterial supply; but the abdominal and pelvic venous turgescence of pregnancy is slow to return to the *status quo ante gestum*. The uterine venous sinuses, the turgid hemorrhoidal veins, the distended pelvic venous channels, and part of the abdominal venous system, are in varying degree dilatory in reducing the expansion thrust upon them by the imperious process of pregnancy. It is probable that the lymph stream shares in the same tardy flow; and this circulatory stasis is a fit element for the growth of tissue, rank and luxuriant, but without the physiological elements of stability. From the venous stasis the uterine tissue is soaked and sodden with exuded plasma; the local veins are distended; the lochia are prolonged, copious and reddish; hemorrhages on exertion or lactation easily recur; later a persistent leucorrheal flux ensues, with correlation in the shape of limp ligaments, and a downward or a posterior displacement of the top-heavy uterus. It is the loss of tone of the pelvic venous system, the paresis of the vasomotor apparatus of the veins, and the ultimate causes of these, that constitute the first obstacle to the restoration of the *post-partum* uterus to the normal.

The Secondary Issue is Deranged Tissue-generation.

The second defect is a trophic defect.

Following hard on the heels of aberration in vascular dynamics come aberrations in tissue regeneration. The uterine tissue, as specialized for gestation, is rapidly disappearing, but with choked lymphatics, sluggish venous efflux, and a fluid-logged stroma; the newly constructed uterine tissues are far from the normal physiological type. Defective pabulum means impaired reconstruction; and this holds good over the whole area of perturbed circula-

tion. Replacing the disintegrating gestation-muscle there arises a mass of muscle cells, rank and luxuriant in growth, possessing none of the normal attributes of stability. These cells are rapid in growth, bulky in outline, inert in character, and limited in duration of life. They gradually are displaced by the more lowly connective tissue stroma; this less specialized structure, requiring less elaborated pabulum, increases and multiplies, gradually constituting more and more of the uterine mass, till in extreme cases scarcely a trace of muscle is left. The scene is now transferred from sub-involution to chronic metritis; and constitutes in the lower classes so frequent a condition as to be facetiously dubbed "Hospital Uterus."

Not here do the effects of *post-partum* trophic aberrations terminate. The uterine mucosa is reconstructed as defectively as the other uterine tissue elements, and in its constant and copious catarrh, and its accompanying menorrhagia, manifests its own departure from a healthy type. It protrudes through the rolled out uterine lips, and in adenomatous over-growth is obvious as the so-called uterine erosion. The abdominal tissues partake in the pelvic changes; and in the lax abdominal walls, the protuberant abdomen, the atonic and distended intestines, we see remoter evidence of the general wave of defective tone and nutrition, which is manifested chiefly in the pelvic tissues, because here the necessity for rapid reconstruction is paramount.

Sub-involution is an Issue to be Controlled by Preventient Measures.

We should regard sub-involution as an issue as preventible as is ophthalmia neonatorum or puerperal septicæmia. To control the *post-partum* changes by which the uterus is restored to the latent condition we must have a clear conception of the lines along which perturbing factors work. The scheme I have presented to you reduces these to two:

aberrations in circulation and primary aberrations of the nutritive centers. If all roads lead to Rome, so may influences the most multiple and varied engender one or other of these discords, and destroy the rhythm of the uterine regeneration. Any cause, therefore, which depletes the bodily vigor, such as visceral and especially renal disease, or pyrexia, or insufficient food, or unhealthy environment, or any cause which embarrasses the pelvic or portal venous circulation, such as the uric acid diathesis, or constipation, or a too early resumption of the erect posture; or any process which inhibits the normal tone of the trophic centers, such as marked hemorrhage, or mental anxiety, or any radical defect in nerve nutrition; these and many other perturbing factors may eventuate in a tardy return of the uterus to the *status quo*. *Tolle causam* is as essential a cause of successful practice here as elsewhere.

So much for the prophylaxis of the individual. To stay here would connote intellectual blindness as to the ultimate factors at work in the induction of these phenomena. Our observation must take a higher flight and an ampler sweep. Rational modes of life afford us striking object lessons in the prophylaxis of nature against this and other uterine defects. Given a healthy and balanced rational routine of life, the prophylaxis is adequate; but under an artificial routine of the mainly urban type, the protective scheme of nature breaks down, and requires therapeutic supplement.

On the foregoing we can base a practical scheme for the effective treatment of sub-involution. The remedies for this condition naturally distribute themselves into two series, those rectifying the uterine and pelvic circulation, and those controlling uterine nutrition. Thus some such grouping as this results:

SUB-INVOLUTION.

Remedies germane to the Circulatory Defect.	Remedies germane to the Trophic Defect.
Nux vomica.	Kali carb., chlorat., bromid., etc.
Belladonna.	Aurum met.
Lilium tigr.	Aurum et kali chlor., etc.
Sulphur.	
Pulsatilla.	
Etc., etc., etc.	

Potassium Salts have a Specific Affinity for Non-striped Muscle, and Kali Bromatum electively upon the Uterus.

Recent investigations on which I have been engaged point clearly to the fact that potassium salts exert a specific influence on the nutrition of the uterus. The potassium compounds do not manifest this control in an equal degree; the bromide, chlorate, and carbonate rank highest in this quality; to these may be added the chloride, a little used salt, but exhibiting the potassium characteristics peculiarly well.

The rôle of potassium in the life-history of the uterus is extensive and peculiar. Forty per cent. of the mineral structure of the uterine muscle consists of potassium. As iron is to hemoglobin, as lime is to bone, as sodium is to bodily fluids, so is potassium to unstriped muscle. Its presence, and that in relatively large quantity, is essential to the integrity of the uterine muscle fiber. In no other tissue is potassium heaped up in such quantity. Clearly, therefore, when the uterine mass, as a *post-partum* necessity, is being rapidly regenerated, the trophic ganglia of the uterus have to quickly assimilate relatively large quantities of potassium into the rapidly growing muscle.

The striking counterpart of this is that pharmacologists are unanimous in ascribing to potassium in concentration an undoubtedly poisonous action upon non-striped muscle. Brunton shows clearly how small quantities of potassium

salts invigorate this structure and increase its capacity for work. While stronger solutions paralyze and destroy the vital activities of the smooth muscle, of which the uterus is a conspicuous specimen, potassium salts thus stand to the uterus in the triple relation of food, stimulant, and poison, these qualities being determined solely by the dose. I regret I am unable to cite any reliable observations on the results of the exclusion of potassium salts from the dietary.

Potassium Salts Essential for the Rapid Regeneration of Uterine Muscle Fiber.

Now the working hypothesis I have to present to you, based on these considerations, is that often after parturition the uterine trophic ganglia are unequal to the strain of the rapid manufacture of normal muscle fiber; that the uterine tissues thus generated are defective in vital and chemical integration; and that in part this defect is shown in the insufficient incorporation of potassium salts into the new muscle.

The physiological provings of the salts of potash show that the combinations of this alkali act primarily upon nerve ganglia, and secondarily upon muscle fiber. That this influence is of a trophic character seems to me highly probable; and the more so in that parallel phenomena are seen in the similar action of other drugs on tissue nutrition. Dr. Hughes has enunciated the proposition that of mineral elements used in bulk for tissue building, small doses, acting dynamically, will control the trophic process of selection of these from the food. Thus the administration of small doses of iron will accelerate the integration of iron in the hemoglobin; small doses of lime or silica will stimulate the tardy absorption of these elements from the nutrient fluids; and I believe that small doses of potassium will increase and multiply the power of the nascent uterus in assimilating potassium salts in the requisite degree.

Now what clinical warrant have we for the employment of potassium salts in cases of sub-involution? Lawson

Tait speaks of these in the highest terms as effective in restoring the sub-involuted uterine muscle to the normal. Bromide of potassium, says he, is a specific cure for simple sub-involution, but the benefit is derived from the potassium, and not, as is usually supposed, from the bromide. Bromide of sodium has had no such markedly beneficial results as the bromide of potassium; but the effects of this latter are quite equalled by those of chlorate of potassium.

This testimony, though specific, is in its nature empirical, and leaves the warrant for the use of potassium bromide and other salts as nebulous as before. I, seeking for an adequate explanation, was led to correlate the preponderance of potassium in smooth muscle, generally, with its therapeutic use in the constructive defects of sub-involution. Further, my experience with this remedy is, as with iron, that fractional doses are necessary in some cases, and tangible quantities in others. My dosage ranges from five drop doses of the 1x solution to five grains thrice daily; the clearer the indications are for the potassium bromide the minuter the dose; but I do not find it necessary to go beyond this maximum limit. Of the salts of potassium, the bromide is selected by nature to cover the widest area of abnormal pelvic conditions. Affections of the uterus proper are intimately bound up with extensions of the process to the other reproductive organs; and in the bromide we find a special capacity to deal with such extra-uterine lesions. Potassium bromide possesses an amplitude of powers to cope with associated uterine and ovarian troubles that no other potassium salt owns in any similar degree.

The Overgrowth of Uterine Fibrous Tissue in the Later Stages of Sub-involution.

The first stage of sub-involution corresponds to the genesis of deteriorated muscular fiber. The second corresponds to the replacement of this unstable growth by connective tissue. Trophic and circulatory defects, fatal to

the continuance of a specialized tissue like muscle fiber, offer no let or hindrance to the free and unrestrained growth of a lowly structure like connective tissue. Thus the altered circulatory dynamics, and the inhibition of adequate trophic control, allow the abnormal muscle cells to be weeded out and replaced by the more hardy and less differentiated connective tissue. Sachs has pointed out how, in botanical matters, a lately introduced plant of a hardier type will gradually eliminate and replace the greater part of a less robust congener. The same process occurs in the case under consideration. I do not say the normal muscle is totally replaced; for even in the most chronically impaired uterus there exists a remnant of germinal muscle cells, awaiting more favorable conditions to regenerate the normal uterus. So that in the later stages of sub-involution, a double process of rectification is necessary to stimulate the growth of normal uterine muscle, and to remove, as a pathological product, the connective tissue mass which has replaced it. I have spoken of the sphere of potassium in the former function; I now wish briefly to dwell upon the fitness of *aurum* for the latter.

Aurum in the Later Stages of Uterine Sub-involution.

The provings of aurum are hitherto, where reliable, too insufficient to deduce any such property therefrom. Clinical experience, up to the present, furnishes the only legitimate warrant for the use of aurum in uterine induration. Farrington goes a step farther, and says: The prolonged action of gold "causes a tendency to an overgrowth of fibrous tissue, whence result cirrheses." And again, that "gold has been used remedially for prolapsed and indurated uterus."

Hughes mentions the satisfactory experience of a French colleague with salts of gold in the treatment of uterine induration.

Hale extols its action in cases of chronic metritis, but gives no specific indications for the time or manner of its use.

A writer of the *Hahnemannian Monthly* for January, 1894, speaks of gold in the same way ; but goes on to add that the salts of gold show in their provings the influence of their component parts. In the statement I entirely concur.

The Value of Aurum with Potassium as a Double Salt.

What emphasises the selection of gold for this condition is the influence upon the circulation, specially where there exist congestive areas. It divides no honors with potassium in vivifying atonic uterine muscle, but a chemical combination of the two elements promises a resultant action which shall, in whole and in detail, effectively counter-check all the morbid elements of sub-involution. I found, on inquiry, that no such salt was in use ; I obtained expert opinion that it was a possible salt, and commissioned Merck, the eminent chemist of Darmstadt, to send a supply. I have had this properly attenuated and have used it, both in hospital and private practice, somewhat extensively and with very gratifying results. Here is a specimen case :

Mrs. X., æt. forty, now living in London, was kindly referred to me by Dr. Madden for treatment.

Her case was a typical one of the later phase of sub-involution, or chronic metritis. The uterus was much enlarged and bulky, the sense of bearing down was acute, backache pronounced, and constipation obstinate. A hyper-irritable condition of nerve, with frequent headaches, co-existed. But more important than all was a drenching metrorrhagia, so copious that it in itself formed a symptom of magnitude. She had, years ago, been curetted by a colleague for a similar condition, and I was inclined to fear a necessity for its repetition. Dr. Madden put her on a long course of the double bromide of potassium and gold, and in four months' time kindly sent her to report progress. The change was notable, and fairly surprised me in its extent and character.

The remedy was systematically continued for some months longer, when the patient by letter reported herself as well, and spoke in the most definite terms of the efficacy of the remedy in removing her earlier and most troublesome symptoms.

Summary.

I regard potassium salts as a nutritive necessity to the regenerating *post-partum* uterus.

I regard potassium salts, used in dynamical preparation, as essential for the rectification of those trophic aberrations which constitute the early stage of sub-involution.

I regard potassium salts, in their action on a sub-involved uterus, as acting essentially in a manner similar to iron in anæmia or calcium or silica salts in rickets.

I regard the conjoint use of some remedy out of series I. as necessary where a potassium salt is given, for the necessity is twofold—circulatory and nutritive.

I regard the use of aurum in the later stages of sub-involution as most valuable in the treatment of the indurated uterus, and its combination with potassium as furnishing an ideally complete drug, for the treatment of the main issues in sub-involution.

These views I have carefully worked out in practice, and I now commend them to your favorable reception.

Heredity of Twin Bearing.—Von Speyer (Mittheilungen aus kliniko und med. Instituten der Schweiz), detected hereditary tendency in eight out of a series of twin bearers under his observation during the past ten years. In one patient it was found that four generations in her family had borne twins. In several the twins showed feeble vitality, and died almost simultaneously soon after birth. Twin bearing does not seem particularly related to the prime of the generative period, nor to its earlier or later stages. In some families already blessed with twins, triplets and quadruplets were borne. These rarer forms of multiple pregnancy are undoubtedly hereditary.

TREATMENT OF PUERPERAL SEPSIS.*

BY

SHELDON LEAVITT, M. D.

AS I take up briefly the matter of treatment, I shall entirely omit preventive treatment, not because I regard it as of the least importance, but for the sake of circumscribing the time which I shall take. We are all familiar with the discussions, warm and animated, which have been held in medical societies in days gone by, on this subject of puerperal fever, or puerperal sepsis. Some have maintained that it is a distinctive fever, while others have, for many years, insisted that it is nothing more or less than a septic fever, possessing no special characteristics of its own.

The matter of opinion in regard to this has influenced the treatment more or less. I believe it happens of late, however, that a majority of obstetricians and physicians in general have come to the conclusion that puerperal fever, as we have learned to call it, is really puerperal sepsis. With regard to the treatment, even when this character has been given the disease, there has been a great deal of discord. We, as homeopaths, have many of us taken the position that we should rely mainly upon homeopathic remedies, no matter whether it is a distinctive fever, or a sepsis. You will learn, however, from what I have to say this evening, that, for my own part, I have come to the conclusion that we should not place too much reliance upon wholly medical treatment. Homeopathic remedies are good under nearly all circumstances and effect a certain amount of improvement, but I believe when we face a case of puerperal sepsis, that we should hesitate about commit-

* Chicago Homeopathic Society.

ting ourselves and the patient to a treatment by the use of homeopathic remedies exclusively, or a treatment which will oblige us to depend in the main upon the action of these remedies.

We have a poison taken up into the system and taken up ordinarily from the genital tract. Most frequently, I believe, the trouble in marked cases of this character begins within the uterine cavity, and from there it is liable to extend; in the worst cases it involves the peritoneum and we have septic peritonitis. If we believe that the septic material is originally within the uterine cavity, or even within the vagina or at the vulva, it seems reasonable that we should endeavor, as soon as the first threatening symptoms manifest themselves, to get rid of what septic material still remains, that the system of the woman may not be thoroughly poisoned. Of course, we cannot expect, by the administration of remedies alone, to accomplish any such purpose as this, therefore we are called upon to interfere by mechanical or manual means and to remove this offending detritus. This, of course, would mean that we should put the patient more or less under surgical treatment; if we interfere with instruments, it does become surgical in its character. This is, as of course you know, a surgical age, and I believe truly that we cannot afford to leave puerperal sepsis out of the domain of modern surgery.

You will ask me, perhaps, just what means I should use in these cases to remove the offending material. My own preference is most decidedly for the curette. It has been a common custom—I say “common” and I mean it—and is still a common custom among many practitioners, upon the advent of septic symptoms, to irrigate the uterine cavity. Some maintain that irrigation is all sufficient and that, in most cases, it accomplishes the purpose and perhaps just as well as if preceded or accompanied by curettement. It is possible that this would be effectual if it were always thorough. I have been called in a number of in-

stances to see cases of puerperal sepsis and have been told that the uterine cavity had been douched, perhaps repeatedly. I was not surprised to find that the symptoms of sepsis had continued; they might have continued for a time, even though we had made sure that the cavity had been thoroughly cleaned. But, upon making examination and subjecting the patient to curettement at that visit I have satisfied myself that the irrigation had not been at all thorough. Now it is not an easy matter, by any means, some days after delivery, to wash out the uterine cavity. You may or may not have a douche tube with a return flow, but you will find it difficult unless you place the woman in a favorable position, go at the case in a semi-surgical way, get at the uterine cavity and wash it out in the proper manner. The usual douching so many times is nothing more than throwing a stream part way into the uterine cavity. The tube is put into the vagina and perhaps part way into the uterus, but the stream does not reach all parts of the cavity and hence does not accomplish the good which might result from thorough work. I have not depended upon irrigation, but in nearly all instances where I felt that the uterine cavity ought to be cleared, I have done it by means of the curette, followed and preceded by irrigation, and I have felt that the curette brought away a great deal of detritus which the irrigation would not have brought. I have convinced myself that curetting has offered the patient a better chance of life than irrigation alone could offer.

You may ask if this is the treatment in full for puerperal sepsis. Not in full, but in the main. I can easily remember the time when we did not interfere in this class of cases—let them develop high temperature and other signs of septic infection and still relied upon the internal remedy. We perhaps thoroughly douched the vagina, but did not go beyond this in cleaning out the genital tract. We did not so thoroughly appreciate the fact that the cavity of the

uterus is the part at fault. We used to give *veratrum viride* to bring down the temperature. We would hammer away at that temperature, believing that if we could bring that down, the patient would be greatly improved. Remedies like *veratrum* accomplished something and many times brought down the temperature without doing the patient any real good. The trouble still existed and the system was still absorbing the septic matter from the foul uterine cavity, and my recollection is that a large proportion of those who developed these septic symptoms died. In Hahnemann Hospital, years ago, we used to have a great many deaths from puerperal sepsis; it is indeed a rare thing to have a death from such a cause now. We have not had such a death for four or five years, and I should be indeed surprised to see a marked case develop and run the usual course. The temperature does run up occasionally, but for the last two or three years I have gone at them in this energetic manner and have convinced myself that the treatment has, in many instances, been thoroughly effective as a means of saving life.

We have our women delivered, watch the cases attentively, and find that in a great proportion of them, probably forty-nine out of fifty, if not ninety-nine out of one hundred in private practice, run along very smoothly; no elevation of temperature, no indication or septic infection. We feel greatly elated and begin to think that perhaps the success is due mainly to our peculiar management of this class of work. Maybe, after a time, we do find, to our surprise, a case which develops high temperature and other symptoms accompanying septic troubles, and then we are called upon to use the *best* way, not to reduce the temperature alone, but to rescue that life. The temperature in the puerperal state does sometimes mount up to a certain height, and, perhaps, occasionally continues at considerable elevation where there is really no septic infection, but it is safer for us to believe, as a rule, when we find the tempera-

ture going up, and to act upon the belief, that the elevation of temperature is probably due to sepsis. We may at times be led to energetic treatment along the lines I have mentioned only to find, a little later, that the real cause of the elevation of temperature was not to be found in the uterine cavity, but I believe, at the same time, that if we have interfered in a careful and aseptic manner it does the patient no harm. I have yet to see a case where thorough irrigation and careful curettement of the cavity has given rise to any indication of damage to the patient.

I almost believe that it would be good practice—if carefully followed, understand—to gently curette the uterine cavity immediately after delivery. Some two or three years ago, at the Washington meeting, I advocated the curettement of the uterine cavity, as a rule, after abortion, believing that the interests of the patient would thus be best subserved. I have not changed my mind since, but have become more thoroughly convinced that it is good treatment, and the time is not far distant when the medical attendant upon a case of abortion or miscarriage will be called upon, not alone to put his finger into the cavity and remove what may remain, but to carefully curette it, without waiting for the development of special symptoms which we now recognize as calling loudly for such treatment. You will infer then, and that is exactly what I mean, when in puerperal cases you find the temperature running up to some height, and the pulse probably correspondingly high, that you are justified, surely,—to use no stronger word,—in assuming that the high temperature and pulse are due to septic infection, that very likely this has been taken up from the uterine cavity, and that you are further justified in interfering to the extent I have indicated, namely, thorough irrigation and thorough but careful curettement of the uterine cavity. I sometimes hesitate to recommend interference of this sort to the general practitioner, because I have seen so much filthiness in obstetrical practice. It is

an exception for me to be called to a case of labor, or to visit a puerperal patient, and find that the attending physician has been at all thorough in his asepsis or antisepsis. He may have used antiseptics, or washed his hands a number of times, but perhaps has spoiled it all by some carelessness or oversight. We may wash the hands and thoroughly disinfect them and then, before touching the patient, we may contaminate them and perhaps carry infection directly. I have hesitated about recommending this sort of thing to the general practitioner, and only do so now coupled with the injunction that you must be very thorough in regard to the matter of cleanliness. The patient must be clean, you must be clean, everything coming in contact with you or the patient must be clean and *surgically* clean. If you follow this course I believe you will get the best results, and you will not harm the woman by the treatment I have recommended for puerperal sepsis.

DISCUSSION BY R. N. FOSTER, M. D.

I think all physicians who have paid any attention to the subject will certainly agree with Dr. Leavitt's statement, that if there is decomposing material within the cavity of the uterus after confinement, and it is affecting the health of the woman, it should be removed. We should agree with him in like manner if he had said if there is a portion of placenta retained after miscarriage, or at term, and we have hemorrhage, it would be useless or unwise to depend upon remedies. The remedy is to remove the retained material by curette or otherwise. Giving the homeopathic remedy in those cases is not homeopathy. Homeopathy means giving remedies for a dynamic condition, not for closing the open mouths of arteries. Where we have a poison lying within an organ, in contact with an abraded or absorbent surface, and being absorbed, no one ought to propose, or would propose, if he

understood the situation, to treat the case with remedies, homeopathic or otherwise. And yet I know it is true that we used to treat those very cases with internal remedies alone, and some of us were blamed when we departed from pure Hahnemannian homeopathy. We did not depart from it; we had been applying homeopathy illegitimately. Hahnemann gave a remedy to cure a condition which that remedy would produce; we have no remedies which will produce a decaying placenta in utero, and it is not homeopathic to give remedies in such conditions. Dr. Leavitt will be followed by all of us as long as we are convinced that there is septic material in the uterus; I do not think he will get us all to use the curette every time he finds symptoms of sepsis. I do not say that he would curette only on symptoms of sepsis, but when he discovers a rise of temperature. Even he would not curette, I am sure, if he could trace the symptom to a cause other than sepsis. Suppose he found an inflamed mammary gland, a condition frequently found four or five days after confinement and which gives rise to chill, fever, and symptoms sometimes as marked as those accompanying sepsis in the pelvis; a careful examination would locate trouble in the mammary gland.

Curetting the uterus would do no good here, and I am sure he would not curette in such a case. I want him to give us a little opportunity to get along without the curette sometimes; many of us would do damage with it. He says he never saw harm follow its use; I do not doubt his statement, but not long ago I read an article in one of the gynecological journals, to the effect that curettement was not to be undertaken without serious necessity, because inflammatory conditions frequently followed its use—the writer had even seen death follow it. I believe that the use of the curette three or four days after labor, unless absolutely indicated by something in the uterus, is doubly dangerous, as the uterus is in a sensitive condition, and I

am sure that if Dr. Leavitt thought there was nothing in the uterus he would not curette it. Sometimes the trouble begins in the vagina, or in the ovary, broad ligament, or fallopian tube, and the curette would do no good in such cases. Is there any sign by which we may be guided? I think there is. If we have a certain, very significant odor, which is as distinct from all other odors as is the odor of diphtheria—if we get that peculiar odor of the lochia during the first few days, with chill, fever, nausea, abdominal or pelvic tenderness, etc., there is good reason to suspect that there is something in the uterus. If there is anything in the uterus capable of poisoning the woman, it is capable of creating a smell, and if the lochia is quite indorous there is nothing in the uterus which will cause trouble. I make it a rule never to irrigate the uterus or even the vagina as long as the lochial discharge is free from abnormal odor. I will agree with what the doctor has said—and he may be right and I wrong where we disagree—whenever we know of a good reason to suspect that we have trouble in the uterus. Beyond that I cannot follow him, because I know I should not have as good results if I curetted all my cases showing the symptoms he gave.

The septic material is not necessarily in the uterus; we find rise of temperature after labor sometimes, which looks suspicious and accompanied by bad odor, but a vaginal irrigation may show that the decomposing material was in the vagina, not the uterus. Sometimes this material will be curetted from the uterus, but I have curetted and found nothing. Dr. Leavitt did not tell us his remedies, but contented himself with the remark that homeopathic remedies are not applicable to such cases. Sometimes, about the third day after labor, we may have rise of temperature, up to 103° at times, with pain in the pelvis, and of late we fail to differentiate between this and sepsis. They used to call it ephemeral fever; it has to do with lac-

tation and I have seen many of them recover promptly under our remedies. It is not sepsis, although every rise of temperature is charged to that account nowadays. I think you will not see a case of sepsis disappear in twenty-four hours, as these cases do. When we have all the symptoms accompanying sepsis, the rise of temperature, the chill, the delirium, indicating that the poison has entered deeply, the loose bowels with evacuations of a bad character, the constant nausea and the prostration, *et al*, have we any remedies which are of value? The homeopathic remedies are not applicable; there is no poison which will cause this, so *similia similibus curantur* does not apply here. We need other remedies. *Veratrum viride* will help, but the sepsis goes right on. Do the delirium, the condition of the bowels, or the thirst give us any help? Yes, you may help the thirst, but not the patient. Have we any remedy? I think we have. First, that patient must be stimulated, and, if possible, fed, and I think, in the next case, she must have pheno-sodique, or some similar drug, given not in dilution, nor in heroic doses, but small doses have a very marked effect, say one-half or one teaspoonful in a tumbler of water, given every fifteen or twenty minutes. It will improve that condition. We get our results from assisting the power of the organism to more readily absorb the septic material and to properly eliminate it. I am glad to have heard Dr. Leavitt on this subject. He is always clear and straight on any subject and I hope he will not find fault with me because I do not use the curette as often as he does.

THE TREATMENT OF MENINGITIS IN CHILDREN.

BY

O. EDWARD JANNEY, M. D.

WHETHER cases of meningitis are of more frequent occurrence than formerly I know not, but it is true that an unusual number have come under my notice of late.

It is possible that the grippe may be one cause of this apparent increase, since it must be evident to every careful observer that the prevalent epidemic closely resembles the first stage of meningitis.

Whatever the cause may be, whenever a case comes under our care, it must receive treatment, and the question at once arises, what means have we at hand to jugulate the attack or to conduct the patient along the pathway of disease through the gateway of health?

Without entering into the consideration of questions of pathology or making a careful analysis of the different forms in which meningitis may present itself, let us direct our attention briefly to therapeutics.

One principle of treatment is that each case should be studied and individualized. The disease is to be studied as it manifests itself in the particular patient under care, and this course is rendered the more necessary owing to the fact that personal peculiarities cause the symptoms to develop in different ways.

Quiet, shade, cleanliness, the application of cold, either moist or dry, anodyne applications to relieve the terrible pain, simple nourishment; in a word, all the details of general treatment adapted to the management of a nervous fever should be carefully carried out.

While meningitis is a most obstinate and almost hopeless disease when in full career, it often yields in its early

stages to the gentle yet powerful persuasion of properly selected remedies.

When the attack first comes under the observation of the physician there will be observed a combination of febrile with nervous or cerebral symptoms.

Napoleon won most of his great victories by sudden surprises and rapid advances before the enemy were prepared for resistance. In like manner the onset of meningitis may be met and its advance checked by means of early recognition of the condition and the prompt application of remedies. The proper ammunition to use in this early skirmish is *ammonium carbonicum*. It will throw the advance guard back upon the main body and produce the formation of a regular line of battle. Or, to put the idea into medical language the remedy will bring about reaction, put the system of the patient into a more natural condition, thus opening the way for a more careful study of the case and the application of the proper curative measures.

Now for the next step. You sit by the side of the patient and study him. The face is flushed, perhaps, the eyes bright and showing a tendency to dilation of the pupils. You take his hand in yours; it is cooler than usual; you touch his feet and legs; they also are cool. You notice that the child is restless, his limbs jerk about and groups of muscles perform a spasmodic dance. He places his hand on his forehead, indicating the location of pain, or else retraction of the head suggests suffering at the base of the brain. Fever and thirst are present. You have now sufficient evidence to justify the employment of *belladonna*.

Pain in the head, neck, and spine is often a prominent and troublesome feature of meningitis; even when the child is in a stupor, he manifests pain by turning the head from side to side, or by putting the hand to the seat of suffering. When the pain is located in the back of the

neck it is accompanied by a bending of the head backward so as to relieve tension, thus making the first step toward opisthotonos. Older children may complain of dizziness, stiff neck, and a sensation as if the parts affected were alternately opening and closing. Now, when this group of symptoms presents *cocculus indicus* will afford relief.

Sometimes the pain is felt not only in the vertex but also at the base of the brain and extends down the neck and to the scapulæ. The pain is aching or drawing in character and is accompanied by exquisite sensitiveness to pressure. This condition demands *cimicifuga*.

When the muscles of the neck are thus sensitive and the head is thrust backward to relieve pressure with a tendency to opisthotonos; when the child is aroused from a state of insensibility by sudden violent jerks which shake the body from head to foot like electric shocks, and a strong tendency to spasmodic attacks is evident, the remedy is *cicuta virosa*. Such selection will be made more in accordance with *similia* if there is also severe gastric pain, accompanied by vomiting and painful distention of the abdomen.

These pains, which seem to dart from the brain through the body and limbs, rendering the tissues through which they pass sensitive to touch, bring *nux vomica* to mind; and should there be present that state of nervous tension which is ready to create a nerve-storm at a touch or noise or jar, our choice of *nux* is a wise one.

In studying a case of meningitis you will often observe a tendency to convulsions. The muscles, especially those of the forearms and the feet, twitch and tremble, the eyes show a strabismic tendency, and there may even be a slight general seizure. If with these symptoms it be noted that the eyes lack luster and are encircled with dark rings, while there is a general sluggishness of peristalsis, the active services of *cuprum aceticum* may be employed to check the

tendency to convulsions. It is one of our most reliable little friends.

It will sometimes be observed that a patient with meningitis presents indications of passive congestion; a face dully flushed, brain inactive, pupils dilated, eyelids drooping, vision clouded, expression lost, muscular power lessened almost to paralysis; the pulse soft, full, and flowing. Accompanying this condition oftentimes is a severe headache, the pain being most marked over one eye and extending upward over the vertex, and with the headache vertigo is experienced. Under these circumstances the use of *yellow jasmine* (*gelsemium*) often yields prompt results.

When cephalalgia becomes increasingly severe and is felt especially in the frontal and temporal regions, sometimes extending to the occiput and back of the neck; when the fever continues high, the pupils unequally dilated and the eyes show a tendency to be turned up, mild delirium alternating with stupor, we know the effusion is about to take place and that *bryonia* is the Moses that will lead us out.

And so it becomes evident that in order to aid nature in the cure of cases of meningitis, we must be able to group the most meaning symptoms, and, having in mind the group of drug effects most closely corresponding to these symptoms, by opposing, end them.

A CASE OF DYSTOCIA. ,

BY

GEO. D. STREETER, M. D.

FROM this caption one might expect that some special difficult physiological process had been witnessed and would be herein delineated. Many and varied are the causes that bring forth this condition which we will defer mentioning, together with a technical classification of this case.

Mrs. A., aged twenty (20) years, primipara, a beautiful blonde, symmetrically formed, with open countenance, large eyes and unconstricted mouth, had always enjoyed good health, sent for me one night thinking that she was about to be prematurely confined, having been but a little more than seven months pregnant.

I hastened to her relief and found her in the second stage of labor, with the child's right hand protruding, which could not be replaced. In passing my hand into the uterus for the purpose of version it was observed that there was little or no pelvic curve, just as if the sacrum was not curved upon itself, but made a direct extension of the lumbar vertebra, and, upon noticing this, cogitation began as to the prognosis, which, at first thought, was very favorable, but the more reflection the more serious appeared the patient's condition, until it was finally decided to be entirely different from what had at first been supposed, and council was at once summoned. Dr. B. was soon on hand and version accomplished without much difficulty. It was also noticed that the sphincter ani and perineum did not advance before the presenting parts, but that the former hid itself, as it were, behind the coccyx, while the anterior perineum slipped down into a roll or cushion on the top thereof.

The uterine contractions were all that could be desired, yet little or no progress was made, and the presenting parts advanced so slowly that the forceps were presently called into requisition and the breech finally delivered. But the head was apparently too large for the space through which it had to pass, and, after much dexterity, with the assistance of the forceps it also was liberated, but not until the little visitor's life had become extinct, supposable from asphyxia by continued unavoidable pressure on the funis.

The mother's recovery was rapid and satisfactory, but before the case was discharged both parents were told that a recurrence might prove fatal on account of the incapacity of the mother.

Time rolled on until about ten years had elapsed, when it was learned that she had again become pregnant. The seriousness of the former experience had partially faded away, and the case was allowed to go undisturbed. Ten months had elapsed since her last menstrual flow before being again called to her bedside as an accoucheur. Her mother said she had been suffering with an occasional pressing down pain for the last twenty-four hours and that a dark, muddy, odorless discharge had been passing from the vagina during that time. This discharge was carefully examined but could not be accounted for. Upon digital examination the external os was found to be sufficiently dilated to just admit the finger, and the examination failed to diagnose the presentation.

Again and again was the examination made, without being able to discover the exact presentation. At one time it was thought that the olecranon process could be felt and that the elbow was presenting; then again, a spinous process of a dorsal vertebra could be detected within the exploring radius, and a back or lateral presentation silently declared.

Having evacuated the amniotic fluid, with splendid uterine contractions, yet no progress, at the expiration of

two hours assistance was called for. Dr. D. was met at the door and requested to examine and name the presentation, which he smilingly promised to do, but, after spending about ten minutes in diligent search for some evidence he informed me that on account of the impaction a diagnosis was impossible.

The dark brown odorless discharge that had so worried her mother suddenly flashed before the memory, and with it the idea that the child's bowels had moved in-utero and that the breech must be presenting. This was imparted to Dr. D., and he fully concurred, and which subsequent dilatation proved to be true.

The forceps were applied and for four long tedious hours did she suffer before being delivered. The excellent uterine contractions seemed to be of no avail only to prostrate our patient, and to the forceps alone we gave the credit of the delivery.

Five hours thereafter the patient's pulse was 130, irregular, and very weak, with a temperature of 102°. The large amount of chloroform she took seemed to so nauseate her that she never recovered from it. Her temperature ran up to 104° on the third day, and it then gradually declined with her vitality, until on the tenth day she died without a struggle, she having made full preparations therefor two days previous.

In recapitulating this case three questions might engage the attention of the critic: First: Would the production of abortion have been justifiable? Second: Did the dark, odorless discharge from the vagina indicate the presentation? Third: Will the abundant use of chloroform in parturition weaken the vital forces?

APPLICATION OF THE FORCEPS.*

TRANSLATED BY
B. F. UNDERWOOD, M. D.

(Continued from p. 73, January, 1896.)

First branch, left pivoted—guided by the right hand.
Introduction of the guiding hand. Introduce the hand

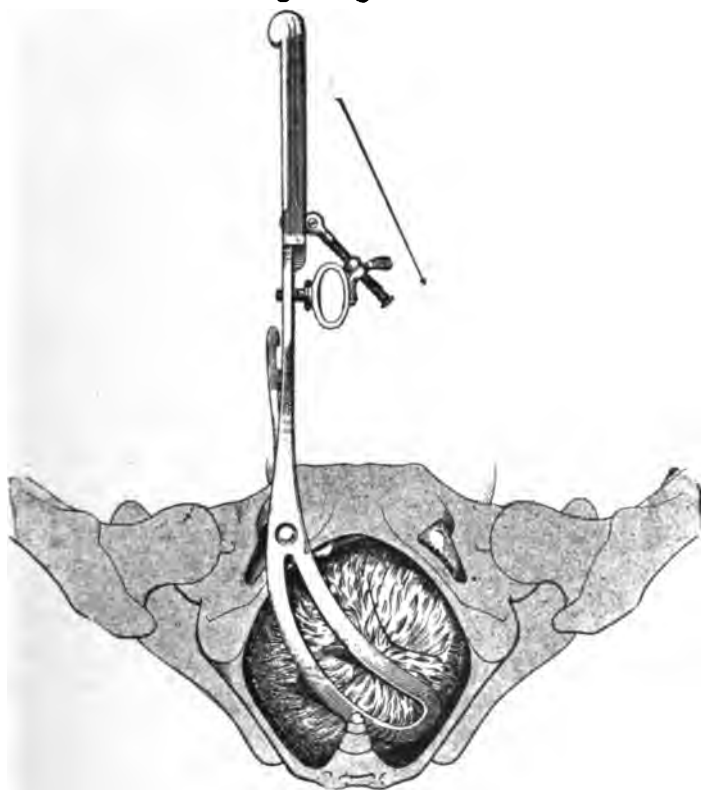


FIG. 27.

which is to act as a guide to the first branch, the posterior, the left, therefore the right hand (fig. 26).

* From the French of Professor Farabeuf and Dr. Varnier.



FIG. 28.

Fig. 27.—Summit at the inferior strait, left anterior occipital position. Direction of the handle a little to the right of the median plane, showing the position of the blade at the moment of presentation to the palm of the guiding hand. It will be seen that if the hook is lowered obliquely in the direction shown by the arrow, the blade will enter backward to the left, covering the parietal eminence and more deeply the cheek.

Proceed as in the direct application. To reach the ear, which in this case is lateral and posterior, carry the hand backward and to the left, gliding upon the walls of the pelvic cavity the dorsal surface of the fingers in attaining the posterior lateral walls, then rise above the sacro-iliac symphysis.

When the entire hand has been introduced, including the thumb, the vulva embracing the wrist, the neck of the uterus will have been felt and passed, and the ear, the lobule of which is a little above the malar bone, may be felt and easily examined. The malar bone should be passed by the beak of the forcep and embraced in the fenestrum. If the index finger is on the ear, the other fingers will cover the parieto-malar line, the line of application of the forceps (fig. 28).

Presentation, introduction, and placing of the blade: When, and only when the guiding hand is properly placed, the forcep, the left branch, is to be introduced, according to the same principles which have guided its introduction (we do not say its placement) in the direct application; the blade in the axis of the guiding hand, the hand which holds the blade being lowered obliquely to descend outside of the right forearm. Remove the right hand and let the left branch rest upon the fourchette.

Fig. 29.—Summit at the inferior strait in the left occipito-anterior position. The first blade in position, backward and to the left, upon the parieto-malar line. The handle is seen foreshortened and sustained by the vulvar ring, the

hook obliquely ascendant (not enough ascendant) was the same direction as the grasping face of the blade.

Fig. 29 shows the result of the first portion of the application. The handle of the left blade, well placed, is a little raised, nearly horizontal, slightly placed to the left of the mother. The hook, which is perpendicular to the grasping surface of the blade, and is the guide to its direction, is raised and to the right.

The handle is now entrusted to an assistant, who kneels to the left and who holds it immovable: this is a very important point. If the assistant raises or lowers the handle, it will cause the blade to enter or retire; if he carries it

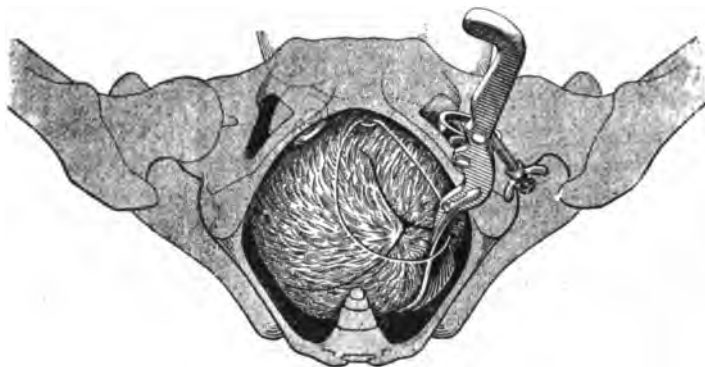


FIG. 29.

toward the right thigh, it throws the beak toward the left side of the mother and toward the nape of the child's neck; if toward the left thigh it will bring the beak upon the eye of the fetus; if the hook is turned it will correspondingly change the direction of the surface of the blade and its seizure.

Second branch—right, notched—guided by the left hand—held by the right hand.

Introduction of the guiding hand. Now, for the second branch, the right, it is the left hand which becomes the guide. Introduce, without the thumb to the right and

backward, between the coccyx and the ischium, as deeply as possible until the ischio-pubic junction arrests the commissure of the thumb and index finger (fig. 30); thus surely passing the neck of the uterus, the orifice of which

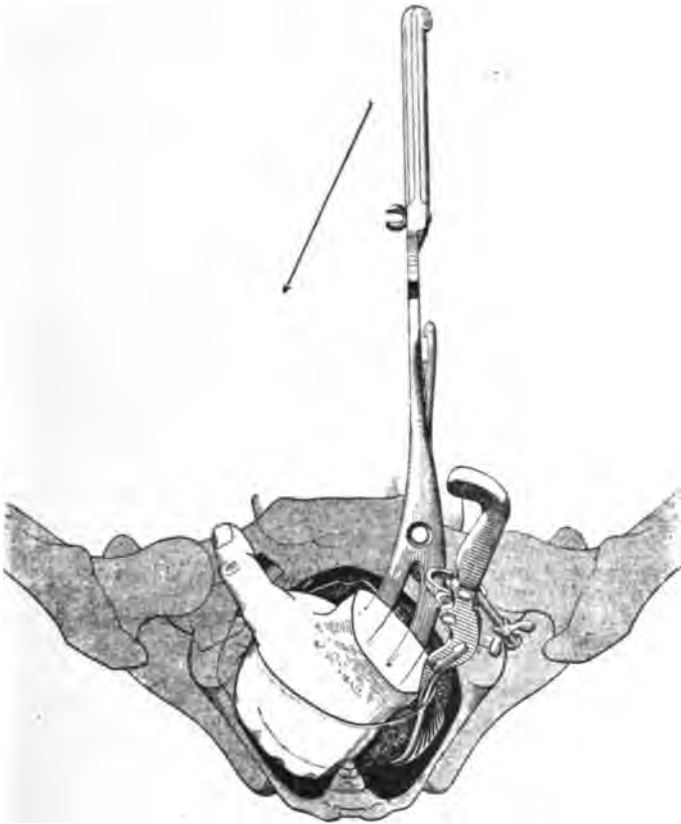


FIG. 30.

should be found and identified. The sagittal suture should be recognized, and passing on, the bregmatic fontanelle and even the frontal sutures may be felt.

Presentation, introduction, and placing of the blade: Upon the left guiding hand, well introduced, knowing its

position, the right blade (the notched) is to be conducted in the line of its axis. The hand holding the handle is to be lowered obliquely to bring it outside of the left forearm. Do not hesitate to push the blade high, without force, of course. It is necessary that the beak should pass the forehead and find a space beyond which will permit the concavity of the blade to adapt itself softly and perfectly to the cephalic curvature. Without this condition, the blade will not be able to glide, close to the head, upon the bregma on the parieto-malar line, on account of the narrowness of the space which separates the forehead from the lateral walls of the pelvic cavity.

To provoke this gliding movement necessary to bring the blade from the right posterior to the right anterior position, being careful of displacing the head and the posterior blade in the use of the guiding hand. Act with the handle in developing, to increase the movement which has been described in the directions for placing the blade in the occipito-pubic position.

Fig. 30.—Summit at the inferior strait in left occipital anterior position. Introduction backward and to the right, of the second guiding hand (the left without the thumb) and of the second blade, the right. The handle, turned a little to the right of the median plane, is to be lowered in the direction shown by the arrow.

This handle (*D* fig. 31), coming from above and from the left (left of the mother), is still raised above the horizon, near to the median plane, going to the right of the mother; the hook turned obliquely upward and to the left the same as the concave face of the blade. Simultaneously the handle is to be lowered, for the beak must penetrate still farther, carried back toward the left thigh, for the frontal eminence throws the blade outward; finally, the hook which was directed obliquely, turned and brought to point directly to the left of the mother, to cause the blade to glide upon the side. The movement will be half made:

the blade should pass beyond the guiding hand and be found upon the side.

While retiring the guiding hand, continue to lower the handle to elevate the beak; turn the hook to pass the blade farther upon the parieto-malar line and stop only when the hook is turned obliquely downward and to the left *D'*.

Fig. 31.—Summit at the inferior strait in left occipital anterior position. Placing of the right blade, the second

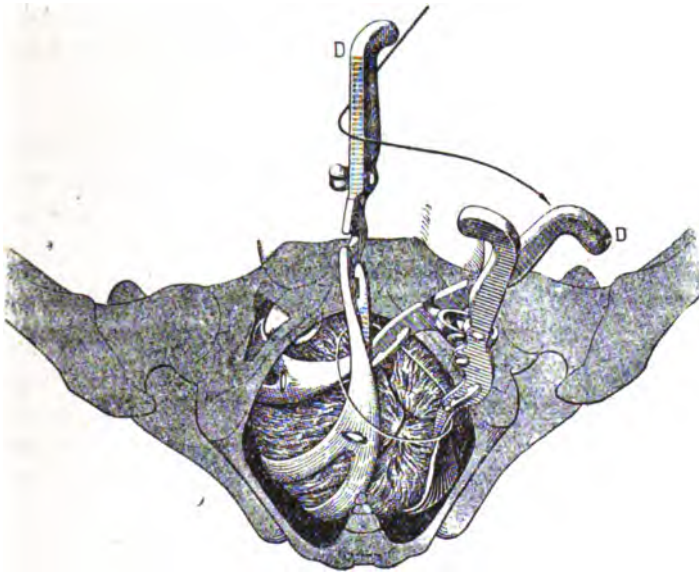


FIG. 31.

introduced, backward and to the right *D*. When the hook will have been obliquely lowered sufficiently to make the penetration complete, it will be brought to the left (of the mother) lowered still and turned, carried from *D* to *D'* and even a little beyond. From the oblique ascendant *D*, it will become transverse and finally obliquely descendant *D'*.

This done, you will see that the handle crosses largely above and to the left of the first placed, taken obliquely,

depressing the fourchette and finally brought near to the left thigh to be applied to its congener.

Some accoucheurs endeavor to leave the guiding hand until the end of the spiral movement, hoping to be able to push on the blade with the index finger. But this hand cannot be easily brought, nor without inconvenience, in advance. And when it remains behind, it continues to project the head and to narrow still the right pericephalic fissure where the blade should be placed. It seems to us better to retire, without entirely removing the hand, a measure which we have advised in the execution of the maneuver of Mme. Lachapelle.

During all the time the execution of the maneuvers of the second blade is taking place, one should not cease to figure the grand spiral penetrating movement which is made by the blade in the pelvis, between the head and the uterine wall.

ARTICULATION OF THE BRANCHES.

When the right branch (the notched) is thus brought forward and applied upon the pivoted branch, it will be noticed that it is a little more deeply introduced than the latter. This deeper penetration has been made to the end that the blade may, in its concavity, turn the frontal eminence and embrace it. The second branch will therefore be retired a little to bring the articulating surface in position, to be united with the first branch. If the application is good, regular, the plane of the articulating surfaces will apply exactly one to the other.

If the spiral movement has been too timidly made, if the blade has been arrested in its course, embracing the frontal eminence in the fenestrum and including the eye with beak not sufficiently entered, the articulating planes will not meet. The blade may go farther without going altogether far enough. Therefore, for the application of the articulating surfaces, sometimes it is too much, sometimes too

little. If it is too little, turn the handle lightly in an inverse sense to bring the planes together. If it is too much, and you know that it is necessary to use force, retire first the last introduced blade by an inverse movement to that by which it was introduced. Retire the blade first placed also if there is the least doubt upon the subject of its placement. Re-examine carefully the position and recommence the application.

VERIFICATION.

The articulation made, remark yet again the oblique direction to the right of the handle in relation to the median plane of the body. This will indicate that the rotation of the head has not been made, of which you may assure yourself by touching with the finger underneath the forceps: you will feel the fontanelle in front and to the left; the sagittal suture marks always the left oblique diameter. The position of the handles of the forceps being that which it should be for the position of the fetus, you know that the application is correct.

MULTIPLE PREGNANCIES.

BY

F. D. CANFIELD, M. D.

IN an experience of thirteen years, I have had but three cases of multiple births, all being very similar in details, all being twins and all girls, and all concerned made good and rapid recoveries. The average time between the births of individual children of each pair being rather under thirty minutes, the average length of the cords being eighteen inches, the average diameter of the placenta being eight inches, and the average weight of the children at birth being five pounds, the average length of confinement to bed of the mothers after the births being ten days. In all there

were double placentæ and cords, other points of similarity are the marked paucity of the world's goods in the possession of the parents, and each parent concerned knew exactly how "blessed is he who has his quiver full." In each case I ligated the cords twice and cut them between the ligatures, as is my custom in all cases, for I can never tell in ascertained cases of multiple births, whether there is a single or double placenta; and if the former, the second child will surely bleed to death if the first cord be not tied. And too often, through hurry or inadvertence, the presence of the second child is not suspected till after the birth of the first. Another point in regard to cutting the cord: I never failed to notice that, let the child be lying never so quietly at the time, it always, and at once, makes a great outcry and struggle when and after I ligate and cut the cord, and acts precisely as it would if sensitive nerves were being wounded, hence I question if cutting the cord does not cause intense pain to the child. If it does, as it certainly appears to, should the cord be ever cut or ligated? And would not this explain the undoubted frequency of spasmodic colic in infants whose cords are so treated? I should like to hear expressions of opinion on these matters from my brethren.

Treatment of spasmodic colic in infants: This trouble I have found, without a single exception that I can recall, to be controlled almost at once by whisky and water, given hot or cold in the proportion of one to five. Let it be maternal, purely neurotic, or dyspeptic in origin, the result has been the same in my experience. I administer this medicament at the time of and during the attack, perseveringly, if necessary, and I have learned to look upon it almost as a specific. I also give the indicated remedy during the day, and have found belladonna indicated perhaps as often as any other single remedy, perhaps because its indications are so easily perceived—the dilated pupil, the suddenly suffused head and face, dry mouth and fauces;

peculiar lancinating pains giving rise to sudden and agonizing cries.

Cracked nipples and cankered mouth: This condition, which often gives rise to so much severe and protracted suffering to both mother and child, and is sometimes so intractable in its nature, I find to be in a very large proportion of cases controlled by equal parts of sulphurous acid and distilled water, applied freely after each nursing to the nipple and areola and dabbed dry with a soft cloth. I give the mother, if her mouth be sore, five-grain tablets of chlorate of potash, one every three hours, and wash the baby's mouth with a solution of borax and water, in which a little sage has been steeped, after each nursing. This treatment I follow perseveringly through the whole course of maternal nursing, if necessary, and have won the gratitude of many a hitherto suffering mother, and have had the satisfaction of seeing many children thrive and grow fat, who otherwise must have suffered intensely or even died.

ENUCLEATION OF THE UTERUS BY THE PRATT METHOD.

BY

B. BELL-ANDREWS, M. D., PH. D.

IT is difficult to place a proper estimate upon the results of contemporaneous scientific discovery or the achievements obtained by those who compete with us in the field in which we choose to struggle for meritorious recognition and preferment.

The saddest travesty on fraternal pretense is too often witnessed when the average medical professor gives his meed to those who have either outstripped or anticipated him in his discoveries. Ideas, like living organisms, are

evolved out of pre-existing ideas, and modified by environment and habitat. No man can say that his thoughts or their results are parthenic.

My uncle, John Bell, conceived the idea of teaching the application of the science of anatomy to practical surgery. His brother, Sir Charles, inspirited by this new procedure, advanced numerous hypotheses, among them the probability of opening the abdomen and extirpating neoplasms. Ethan McDowell, a pupil of Sir Charles', imbued with the great practical value and expedience of his thought, carried it into execution. The variation from the first practical demonstration of his bold concept of Bell's, as executed by McDowell (that we pursue in method and technique to-day) is truly wonderful, and was it not for our being present with this progress we would never cease from wonder and admiration.

The operation for the removal of the uterus is not a modern concept. There are accounts of the uterus being removed as early as the first century of the Christian Era, and we have fragmentary historical evidence that from that time to our day, surgeons were evolving methods for the successful extirpation of this interesting organ. The dangers attending older methods were such as to stay the boldest operator. Not until Conrad M. Langenbeck, in 1813, purposely extirpated a womb by peeling it out from the peritoneal covering, was vaginal hysterectomy looked upon with favor. The specimen being lost, no account was taken of the operation until thirty years afterward, when his son, with others, held an autopsy upon the body of the woman, when the truth and practicability of such an operation was made a matter of record. For obvious reasons the operation fell into disrepute; first, because it was only practicable in a limited number of cases; second, the want of proper instruments; third, ignorance of the effect of compressing sympathetic nerves; fourth, the benefit of cleanliness in operations; fifth, it was easier to tie or com-

press bleeding vessels than to perfect one's self in anatomy so as to avoid dividing the vessels; sixth, the impossibility of early recognition of malignant disease, and means of differential diagnosis in general.

I might here introduce a long list of names of men who have at various times, through the vagina, enucleated the uterus from its peritoneal bed for various reasons, but this history you will find scattered through a number of text books. Wherever this has been undertaken, nearly every one has tied the uterine artery before beginning decortication. It was not until March, 1893, that any surgeon had made a public record of venturing to extirpate the uterus with the sole purpose of avoiding the shock incidental to pinching the sympathetic nerves, or pointed out to the profession with such clearness the cause of shock and its avoidance, when Dr. E. H. Pratt of Chicago, Ill., published his list of a series of cases successfully operated upon at the Lincoln Park Sanitarium. His views concerning shock are, I believe, entirely new and original, and at least places him at the foremost rank as a benefactor to mankind. No operation, or modification of an operation, for hysterectomy has met with the success in the avoidance of shock and low death rate that this one has, which he is first to offer to the profession under varied experiments. I know that professional jealousy has already attempted to belittle his discovery, and to deny him precedence in the operation, but with all this he has gained the proud distinction in a way impossible to be defrauded out of it by his enemies. That it does convert a major into a minor operation in those cases where it is proper to operate by this method, is a fact that is borne out by continued experience. That the pinching of terminal nerve fibers, and tying vessels *en masse*, is to be condemned in future where it is possible to avoid the same is a fact that no surgeon of experience will deny, and on this point Dr. Pratt first called the attention of the profession to the benefits to be derived by avoiding this procedure in vaginal hysterectomy.

Mrs. Minnie A., aged fifty-two years, came to my infirmary for treatment, April 17, 1894. She was suffering from carnosities of the meatus urinarius, which had existed for more than a year, and for which various treatments had been tried by several physicians. While snipping the carunculas out, I noticed that there was a bloody discharge from the vagina; she believed this was caused by a return of the menses after the menopause—in fact, the patient thought that the menstruation had never ceased, and was so advised by her attending physician. Examination revealed an ulcerated os. The posterior surface was spongy, ragged, and bleeding. For three months every known means was employed to heal this, but failed, and the curetted *débris* revealed under the microscopic cells that were pronounced to be undoubtedly those of epithelioma, and on her return home her husband and the attending physician were advised that the patient was suffering from cancer of the cervix uteri, and an immediate operation advised. Three methods were pointed out to the patient; amputation of the cervix, hysterectomy by forcipressure or ligature, or enucleation by the Pratt method. The latter operation I had never performed, but from the favorable reports attending this operation, and looking over the wretched state of my own and other surgeons' cases, the slow, tedious convalescence and shattered nervous wrecks following the older method, I urgently advocated that it would be to her interest to be operated on by the plan laid down by Pratt.

I am glad to be able to bear testimony to its great superiority and advantage, where practicable to be employed, over all other operations so far recorded.

On December 24, 1894, the bowel being emptied by an enema of borated water and the patient thoroughly bathed, the vulva was shaved and scrubbed, the vagina thoroughly irrigated with hot bichloride solution 1-2000, and loosely packed with iodoform gauze. In the presence of Dr. Allen of Humboldt, Neb., and Dr. Melvin of Stella, Neb., assisted

by my two sons, the patient being chloroformed by Dr. Hull of Stella, and placed in the dorsal position, the limbs sustained by a Clover crutch, the uterus was seized with a strong vulsellum and drawn as nearly outside as practicable, when it was quickly dilated, curetted, and packed carefully and tightly with iodoform gauze and the vulsellum turned over to my assistant. The uterus and vagina were again irrigated with the hot bichloride solution. The mucous membrane surrounding the os was cut with a scalpel, a few lines from the cervico-vaginal junction, except at the rectal surface, where the mucous membrane was all taken away and a strip of muscular tissue, on account of the ulcer coming down and involving a space of about one-fourth inch square. Some little difficulty was met with at first, as the mucous membrane here is quite adherent, but with care, and a few snips of the scissors, this was easily overcome. No other instrument was used except a pair of Byford's curved, blunt-pointed scissors. With these and the fingers the uterus was decorticated from its envelope of the broad ligament by pressure of the points kept constantly bearing on the uterine body; adhesive bands being snipped where too much force would be liable to tear the peritoneal envelope. At one point, about the size of a silver quarter of a dollar, between the bladder and uterus no division of the tissues could be made, and it seemed to be infiltrated and hard; suspicion made it imperative that this be removed, which established a vesico-vaginal fistula. The bladder was washed out with a saturated solution of boracic water and closed with five stitches of braided silk, before proceeding with the further denuding of the uterus, as it better enabled me to operate. This fistula only partially closed and was re-operated on last Tuesday with every promise of success. The peritoneal space was not opened until the uterus was extirpated, when a large enough opening was made at the entrance of the right horn of the uterus, by pushing the scissors through to admit a finger. It was

ascertained by this opening that there was no reason for removal of the ovaries or tubes, and was closed by a whip stitch or two of silk ligature. There were no vessels broken or cut and the loss of blood did not exceed twenty grams. The parts were wiped dry, dusted with iodoform, and a tampon of wool in a silk covering was closely and carefully packed into the denuded peritoneal covering, the vagina loosely packed with iodoform gauze, a binder put on, and the patient placed in bed. There was no more shock than in a normal labor. There was a slight hemorrhage from the bladder, and a hypodermic injection of ergotole was given twice at intervals of an hour, which controlled it. The average temperature for the first fourteen days was $99\frac{1}{4}^{\circ}$, the highest being 102° , on the third day, which at once returned to normal by giving a saline cathartic. After forty-eight hours the dressing was removed, and the vagina thoroughly douched with a mixture of N. A. Calendula and boracic acid in sterilized water twice a day for two weeks, carefully guarding the vagina by aseptic wool dusted with iodoform after each dressing. No medicine was given except a few one-half grain tablets of codeine to induce sleep at night, and this was complying with a habit that had been induced many weeks prior to the operation. After the fourteenth day no record of the temperature was kept, as the patient sat up from that day on, every day until the twenty-fifth day, when she returned to her home in Kansas, a distance of over two hundred miles, fifteen of which she made in a carriage, and has, except for the fistula, gradually improved.

One operation is not sufficient data to generalize, systematize, and verify the benefits to be derived by it, yet "Every man's mickle makes a muckle," as the Scotch say, and I am able, by experience with the older methods, having three times extirpated the uterus and amputated seven cervix uteri and opened the abdomen twenty-three times for various lesions, to give an intelligent opinion in such

matters. This is to me the most wonderful operation, whether old or new, as to final results ever devised to get rid of a diseased womb. It is a crime to operate for cancer of the cervix in the early stage of the disease by any other method, and a crime to operate where the disease has sufficiently advanced to involve the peritoneal wall, or when the cachexia is present. It is the operation for retroflexion when other methods fail. It is the ideal operation, when necessary to be practiced, for fibromata and other tumors that are small enough to be delivered through the vaginal canal. For procedentia, after all other means fail.

It is not the loss of the womb that destroys, or makes physical wrecks of so many women, after operation, but it is the destruction of so much sympathetic nervous tissue that kills them. Why then keep up this murderous practice?

HOMEOPATHY IN OBSTETRICS.

BY

W. O. CLARK, M. D.

I BELIEVE it is generally conceded that, as a school, we homeopaths are a rather conservative people. We are ever alive to the issues of the day, fully awake to whatever tends to the advancement of medical science, and "similia" in particular. But we are extremely, though I do not think unduly, cautious about accepting as reliable every new fad thrust upon us.

To our regular brethren do we grant all the fame of the wonderful discoveries of Brown-Sequard, Koch, and many others. We plead guilty to just one so-called irregularity, that of the discovery of Hahnemann years ago, and one that has stood the test of time.

And, can we to-day, as believers and followers of this

law, show reason why we are better obstetricians than are those with whom we compete?

We all know that statistics of our hospitals and public institutions, where the two schools are represented, show that our school is several per cent. in advance in the treatment of most diseases; and, while I do not know that any records have been kept, or could to-day be obtained, as comparison in this branch, I do believe that, could such be shown up, we should find as flattering a balance in our favor as we find in the treatment of scarlet fever, for example.

To homeopathy, I believe, is credited the belief and practice of pre-natal treatment. Who can doubt its efficacy? Surely no unprejudiced mind, or one who has given the treatment a fair trial. Here we can truthfully and conscientiously say, homeopathy can and does show her superiority over any other school of treatment. A dose, or few doses, daily administered to the expectant mother greatly mitigates, if not entirely relieves, her offspring of some latent dyscrasia. How many of these suffering cases of hereditary scrofula and syphilis, in particular, would to-day rise up and call us blessed, if they had only been given proper pre-natal treatment.

While I cannot agree with the belief of some, that the woman to whom pulsatilla is administered during the latter weeks of pregnancy is certain of a normally presenting child; yet I do think that the administration of our indicated remedies during the last month or two of pregnancy makes the patient much more comfortable during this period of treatment, as well as facilitates labor.

Our mechanical skill and good sense in the manipulations, normal and instrumental, of labor, we believe to be fully up to par with that of any other representative. And to one of our brightest lights, Dr. Sheldon Leavitt, is credited one of the first successful symphyseotomies performed in this country,

Then, during the *post-partum* stage is where homeopathy shows many of her most brilliant records. None of your mercuric bichloride poisoning cases do we sign death certificates for. Pure, clean soap and water, a little calendula, listerine, or carbolic acid, clean hands, and clean homeopathy, and what is our record! Success is what we seek, and our works speak for themselves.

The carefully chosen remedy and hot fomentation for inflammations, either of the breasts or within the abdominal cavity. Instead of morphine for afterpains, we would prescribe the indicated remedy. Again the chosen remedy instead of the tampon. Not that the tampon should be wholly discarded, but the remedy, in a large per cent. of cases, will rob the tampon of its necessity.

And last, but by no means least, do we claim superiority in the care and treatment of the newborn babe. All physicians should be good nurses. We believe the most important principles of good nursing should be thoroughly instilled into each student by our college professors.

How often do we hear of the neglect of some newborn babe that is suffering for the want of care, or for some slight remedial relief, the attending physician saying, "Oh, nothing can be done for so young a baby; just wrap it up, lay it where it is warm, and it may come out all right." Or, "Let the nurse take care of the baby; she knows how to treat it." How easy to shift responsibility!

I presume most homeopaths have been called to just such cases, the idea being that we are better adapted to the treatment of babies and children than to adults. Now I consider that a deserved compliment. If it don't require brains and skill to treat a little infant, then I say there is no deeper, more complicated study connected with medical science. To know the meaning and purport of every movement, every position, the expression and delineations observed about the face, is a study whose summit no physician can ever hope to reach. It surely requires better judg-

ment, greater skill to diagnose a baby's than an adult's case, where your patient can talk, and, through language, verify many of the points in the examination.

But being good nurses, and having a remedy, that, thank Heaven, even a baby an hour old can take, we have at our command means for relief and cure. Homeopathy is not ashamed of her colors in any branch of medicine or surgery ; and we believe obstetrics to be one of her brightest examples of superiority.

A RARE OBSTETRIC CASE.

BY

A. B. RICE, M. D.

ABOUT five years ago Mrs. T. reached the end of her first pregnancy. She was a little woman, about twenty-two years of age, energetic, wiry, and had always been well. The labor which terminated the pregnancy was, as related to me, long and very tedious ; but, strange to say, the contractions of the womb were but little painful. Indeed, her husband said that through it all she did not have a single hard *pain*. At the last, the labor was terminated by the use of the forceps, after one or more unsuccessful attempts to apply them, and a dead child was extracted. Owing to her inherent recuperative power she rallied speedily, and had an uneventful recovery.

After a few months she found that menstruation did not return.

At regular monthly intervals she experienced the *menstrual molimen*, but, as she said, "There was nothing to show for it." As the month passed the pain at the time of the period increased until a physician was called, who made a diagnosis of atresia of the os, with retained menses, and by means of a trocar and canula evacuated about a

quart of menstrual secretion, and left the case to the kind care of nature. The opening was made, as the physician recently told me, "As best he could; he thought through the os." However this may be, menstruation followed regularly for five years, during which time the woman enjoyed good health.

About nine months ago she found herself again pregnant. The previous labor had not been forgotten, but being very anxious for a baby, she rather rejoiced at the prospect, and hoped for a successful issue.

Near the close of her pregnancy, which had been normal in all respects, she came to engage me to assist in the final act, which, it was sincerely hoped, would give her a living child; and, although she lived twelve miles away in the country, I promised to attend at the confinement.

September 20, 1895, the summons came, and, upon reaching the place, it was found that for thirty-six hours she had had regular contractions of the womb, beginning at intervals of half an hour, and gradually increasing in frequency until the time when seen, when they recurred every five minutes. That they were real contractions of the womb was evident, since it could be felt to harden, and at the the same time become rounded and more prominent. But the singularity about the case was, there was not the slightest pain connected with the contraction. She said there was a rather disagreeable pressing feeling, but no pain whatever, and she had slept well the preceding night notwithstanding the fact of the frequent recurrence of this effort of the womb.

An examination per vaginam was made, but the os uteri was not found.

After about three hours labor a second and more careful examination could not detect the os. The fetal head, for there was little doubt that it was the head, had entered the superior strait, pushing the lower segment of the womb before it, which also was drawn closely over the presenting

part, and thus the whole of this portion of the uterus was brought within easy reach of the examining finger, and notwithstanding the diligent search made the os could not be found.

But during these three hours the contractions had become less frequent; the patient was perfectly free from pain; she was up and about the room, and as happy as she could be with a labor before her; her meals were taken regularly, and, but for the fact of the uterine contractions, her condition was the same as for the last few weeks.

It was decided therefore to leave the case for a while without interference, in the hope that softening and dilatation might take place after a longer period of contractible effort on the part of the womb.

Twelve hours later a second summons was received, and hurriedly responded to. At this time the contractions recurred every five minutes, and now were painful, the pain beginning about six hours previously.

A vaginal examination both in the dorsal and left lateral positions was made, and a painstaking search prosecuted over every part of the lower uterine surface, which, pushed ahead of the fetus, was well down in the pelvis. Especial care was taken to examine the posterior part of the presentation, since, as is well known, the os is sometimes found with difficulty when there is an anterior obliquity of the uterus. But still the os uteri could not be found.

To complicate matters, the nurse said "the waters" had been escaping for some time, and I could myself see the evidence in the bed, which was quite wet. There was also a slight bloody tinge to the mucus that escaped from the vagina, resembling very much the blood-streaked discharge from a dilating cervix. Of course, if "the waters" were escaping, there must be an opening somewhere. An hour of anxious waiting and thinking followed, an exploration made again, but with the same result as before; there was one thing learned, however, pressure with the finger behind

the pubis provoked a flow of waters ; but instead of amniotic fluid the flow was urine. The pains were strong, frequent, and painful, but lacked expulsive character. The fetal head, now clearly recognized by the bony hardness felt through the tissues and the regular vaulted shape of the cranium, was well engaged in the pelvic cavity. By sweeping the finger over the vertex, a circular patch, about two inches in diameter, could be distinguished as a little smoother and thinner than the surrounding parts, but there was no sharp line of demarkation, and it was impossible to tell where the one part ended and the other began. I felt forced to the conclusion that there was an occlusion of the os, probably the external os, and while nature was struggling to open the womb, the firm cicatricial tissue, stretched by the pressure from above, was successfully resisting all her efforts. There was not the slightest opening into the womb, not a dimple even. The vagina was becoming hot ; the patient was discouraged ; sordes were beginning to show upon the teeth and lips ; the pulse was rapid, and the face haggard. What was to be done? What could he done? Evidently something must be decided upon without farther delay. Counsel had been sent for, but was miles away, and even then responded slowly.

I had never seen or read of a similar case. It seemed to me that a crucial incision made at the most dependent point of the uterus must be the only way out of the difficulty. But before attempting this, it occurred to me to try and break through the obstructing membrane with the finger.

Accordingly the corner of the index fingernail was brought to bear upon the smooth tissue over the vertex, and partly by tearing and partly by boring a few minutes sufficed to make a hole into the amniotic sac, which was announced by a gush of the real "waters." This opening was rapidly enlarged by tearing and stretching in all directions, until the whole of the smooth cicatricial tissue had disappeared. From this time on dilatation progressed rapidly by the

unaided uterine efforts, and in three hours from the time the opening was made, a ten-pound boy was delivered alive and vigorous.

The placenta was expressed by Crede's method, and the patient made comfortable in bed.

Review of the case.—After the first labor there was an atresia of the os, with retained menses, relieved by plunging a trocar into the most prominent part of the uterus, as seen through a speculum. Menstruation took place regularly for five years, the menstrual flow escaping through the artificial os created by the trocar. Then impregnation took place through the same opening, which nature then closed as no longer needed.

At the beginning of labor, therefore, there was no opening into the womb; but as labor progressed, the cicatricial tissue filling the os stretched and thinned by the contractions, and, drawn tightly over the vertex, was a complete bar to successful delivery.

October 2. Baby twelve days old. Mother and child doing well. There have been no afterpains; and there is no secretion of milk. Mother has been up for three days.

When a period of leisure came, a search through such of the works of obstetrics as were at hand shows the following opinions:

Richard C. Norris, demonstrator of obstetrics in the University of Pennsylvania, says: "Atresia is rarely complete, and may be overcome by pressure on the small opening with the tip of a sound or finger. Cicatricial contraction will often yield to Barnes' bags and version or application of forceps before engagement, but may require incisions, controlling the hemorrhage temporarily with clamped sutures."

Dr. Parvin of Philadelphia, in his article in the "American Systems of Obstetrics," mentions two forms of occlusion of the os. 1. A superficial obliteration of the os, which may be broken down by the finger in or as near the site of the os

as possible ; 2. Complete obliteration, in which the tissues are resistant, when incisions as near the os as possible must be resorted to, with subsequent artificial dilatation if necessary.

Playfair, in his "System of Midwifery," speaks of "Occlusion of the Os" as occurring occasionally as a result of inflammation in the early months of pregnancy. He speaks of the cervix and lower segment of the uterus as being drawn tightly over the presenting part, describing the case related above very completely, and adds that in two such cases in the United States, Cæsarian section was resorted to, and the mothers saved. He recommends incisions at the supposed site of the os, and artificial dilatation, but if this fails, either Cæsarian section, or craniotomy, preferably the former.

In our own school, Professor Guernsey says obliteration of the cervix does sometimes occur; he recommends careful search for the os, which is sometimes found high up in the concavity of the sacrum, and if no os can be found, then incisions must be made in the lowest point of the uterus.

Leavitt, in his late work, says a few cases are reported (atresia of the external os). It is probably the result of inflammatory action. "Though these adhesions resist firm uterine contractions, and constitute a bar to labor, they may be broken up by the finger, with loss of but a few drops of blood." He speaks of complete obliteration of the cervical canal as an extremely rare condition, and recommends incisions at the site of the original opening if it can be found.

HYGIENE OF INFANCY.

BY

LAURA JOHNSON, M. D.

THIS is a simple, plain everyday subject, and for this reason is often little considered, giving way to the more technical.

What I have to say will be simple and practical in character. Often our greatest successes depend on the simplest details.

The first and greatest essential in the care of the infant is perfect cleanliness. Sanitary science has done much for the mother, but for the newborn, little has been done to protect it from the various ills with which it is soon to become acquainted.

In no department of medical science is prophylaxis so important and necessary as in the care of the newborn. The ætiology of many forms of infantile ailments is directly due to lack of proper sanitary care at birth and the first few weeks of extra-uterine life. All forms of stomatitis and eczemas are directly traceable to mismanagement in the nursery. The occurrence of ophthalmia neonatorum should be considered little less than criminal.

The hygiene of the infant should begin at birth or even before the close of the second stage. No physician should attend a case of accouchment without having at hand, among other necessary articles, several bits of lint to remove all discharges from the buccal cavity, nostrils, eyelids, cilia, and surrounding parts as soon as the head is extended.

The worst case of ophthalmia neonatorum I ever witnessed was caused by negligence at this time. It required the continual care of two nurses for two weeks at an aggre-

gate weekly expense to the family of fifty dollars, besides taking the chances of having a sightless child.

The first bath of the newborn should be simply of warm sweet oil to soften the vernix caseosa, next the cord should receive attention, this should be dressed with some inert powder (lycopodium preferred), with absorbent cotton held in place by a plain band about five inches wide, just tight enough to retain the dressing and still be comfortable. After adjusting a diaper and a simple slip, the infant should be laid aside in a warm place to rest and sleep.

The daily bath: This is an hour of discomfiture for both mother and child usually, simply for lack of teaching and experience on the part of the mother, when it might be a delightful time to both if properly conducted. An intelligent mother or nurse will make all preparations for a complete toilet before touching the babe. The toilet basket, the fresh clothing, the receiving blanket, soft towels, sponge or preferably surgeon's lint, the bath tub about half full of warm water, from 95° to 98° Fahr., all these should be placed within easy reach before an open fire. Now taking up the child, remove all clothing, place in bath, sponging the front part first, beginning with the head, carefully cleansing eyes, ears, nose, mouth, and armpits, turn it over, sponge the back, quickly and deftly remove from bath, placing in warm receiving blanket. Again beginning with the head, proceed downward, dry with soft towel and give a brisk rubbing which will bring a bright glow to the skin and induce free capillary circulation. Having dried the upper part of the body, put on a soft wool shirt, proceed to the lower extremities, carefully dry, dust, adjust diaper, and put on clothing, which should consist of two slips placed one within the other, putting in the feet and slipping up to the neck fasten with a draw string. The time consumed need not exceed fifteen minutes in place of the forty or fifty exhaustive minutes under the old *régime*. Thus making the daily bath a pleasurable anticipation, from which

the little one comes forth invigorated and laughing for joy and the mother's heart overflowing with a new love. I believe if the daily bath was given intelligently, there would be fewer sulphur children.

To unfavorable bathing and clothing may be attributed a large per cent. of diseases and death among children. Babies are burdened with long, heavy skirts, but as soon as they learn to walk, their lower limbs are left unprotected from cold. Thus we have crippled conditions and tubercular joint diseases due to insufficient protection which favors serious congestion. Much more disastrous than insufficient clothing is too warm clothing. How often we see a babe during the hot summer days, dressed elegantly, with lovely cap, beautiful satin-lined velvet cloak, handsomely embroidered dress, a cotton skirt over a flannel one, warm shirt and flannel bandage, lying on a down pillow in its carriage, looking straight up to the beautiful blue sky. A pretty picture truly. The mother sensibly dressed in the thinnest of fabrics and vigorously fanning herself.

Extremes of temperature have long been known to be disastrous to infantile well-being, but heat is worse than cold. Overheating will surely cause indigestion and diarrhetic troubles. The hygienic essentials of dress, and those most often overlooked, are: sufficient warmth without burdensomeness; uniformity of protection as far as consistent with activity and freedom; and, for children, softness.

Of no less importance than the covering of the infant is the question, Wherewithal shall he be fed? The superiority of nature's provision for the waste and repair of the infant has been so universally acknowledged that it may be said to have become a scientific truth. When this supply is insufficient for any reason, in quantity or quality, other provision must be made. In approaching the subject of artificial feeding there is great diversity of opinion, and every physician will be a "law unto himself," as most

physicians study the subject from a purely clinical standpoint. The recent discoveries in bacteriology throw light on the reason for the old and well-deserved popularity of the use of sterilized milk. It has been found when milk is raised to a temperature of 155° Fahr., all injurious germs which may have found their way into it are destroyed, and the digestibility is increased without impairing the taste or quality of the milk. It is desirable to sterilize the milk daily, consuming it within twenty-four hours. The sterilization should be conducted in bottles containing only a sufficient quantity for one feeding. Various other preparations of milk will be used according to the experience of the physician, viz., peptonized milk, humanized milk, and boiled milk. The cereal foods and meat preparations have their advocates, also the various commercial preparations.

Whatever form of food is used, the care of the bottles, nipples, and all utensils is not the least important. When not in use they should be kept in a solution of bicarb. soda and carefully cleansed before using.

Without proper nourishment in early infancy no child can develop into the fullness of adult health to which he has a right. Malnutrition is the basis of all morbid processes. The prophylactic physician will not leave the future welfare of the little ones to the uncertainty of ignorant mothers or the carelessness of incompetent nurses, but will watch the little ones and see to it that the mother is properly instructed in all that is purely within the province of every intelligent, loving mother.

Book Reviews.

All manuscripts for publication, and all books for review, in this journal should be sent to the Publication Office, 78 Maiden Lane, New York.

AN AMERICAN TEXT-BOOK OF THE DISEASES OF CHILDREN. Including special chapters on essential surgical subjects; diseases of the eye, ear, nose, and throat; diseases of the skin; and on the diet, hygiene, and general management of children. By American Teachers. Edited by LOUIS STARR, M. D., Physician to the Children's Hospital, etc., etc., assisted by THOMPSON S. WESTCOTT, M. D., etc. Philadelphia: W. B. Saunders. 1895. Royal 8vo, 1190 pp. Cloth, \$7.00; shp., \$8.00; one-half mor., \$9.00.

This very handsome volume, profusely illustrated with woodcuts, half tone and colored plates, practically a cyclopedia as well as a working text-book, consists of a series of original articles upon the diseases of children from the pens of some sixty distinguished physicians, representing the teachings of the most prominent colleges in the country, most of the papers being from the pens of specialists in the treatment of the diseases about which they write. Knowing this, it is scarcely necessary to say that the work is complete, thorough, and accurate, and presents the practice of to-day in the dominant school, and as such will undoubtedly long remain a standard work. The illustrations are exceptionally good.

DISEASES OF THE LIVER. Jaundice, Gallstones, Enlargements, Tumors and Cancer, and Their Treatment. By J. COMPTON BURNETT, M. D. Second Revised and Enlarged Edition. 244 pages. 16mo, cloth, \$1.00 net; by mail, \$1.05. Philadelphia: Boericke & Tafel. 1895.

It is a distinguished merit of Dr. Burnett that he not only always has something to say that is worth saying, but that he says it uncommonly well. It was so well said in the first edition of this book, and so well worth the saying, that the edition was speedily exhausted, and the cry was still for more, so that the second edition had to be published. In the present edition, Dr. Burnett has added two parts to the book, one to precede the

original work, which is designated "Part I. The Autonomy and Hegemony of the Organ in the Organism : Being remarks introductory to the cure of Organ Diseases by Organ Remedies in reference to Diseases of the Liver," which precedes the matter of the first edition, and "Part II.," which follows and contains much new clinical matter.

The distinctive feature of this book is the treatment of the liver diseases by what the author terms "organ remedies."

"I have for years," he says, "fought for the recognition of the organ in the organism from the clinical side, and maintained that organopathy lies at the very root of homeopathy in its simplest and most elementary form, and now that orthodoxy is officially proclaiming "organotherapy."

By the term organopathy is understood a treatment of certain organs by certain remedies that have a direct and positive action on them ; an extension, not an antagonism to homeopathy. "The book is intended," the author says, "to show that the greater or more common diseases of the liver can, for the most part, be readily cured by hepatics or liver medicine." A fact which he demonstrates.

DELICATE, BACKWARD, PUNY, AND STUNTED CHILDREN. By J. COMPTON BURNETT, M. D. 152 pages. 16mo, cloth, \$1.00 net. Philadelphia : Boericke & Tafel. 1896.

"The best treatment of the backwardness of children which one usually encounters consists in gymnastic, climatic, hygienic, and dietetic advantages, together with special methods of instruction, all of which proceedings may be more or less sound and laudable, but in many cases they are not sufficient. The treatment which I here advocate does not exclude any of these before-mentioned measures, but it is something quite different, viz.: the use of specific homeopathic, organopathic, and various other constitutional remedies systematically administered, so as to rectify the wrong underlying the said backwardnesses, to cure the diseased organs or parts, to arouse them medicinally from torpidity, or to cure the diseases of the individual as an entirety, or to get rid of the perverted or other morbid conditions due to hereditary diseases and taints, or to shocks, falls, blows, fits, or other previously overcome accidents and disease." This passage from

the introduction to the work shows the scope and character of the book. The cases cited throughout the book, showing the author's method and manner of applying these principles, mark him as a master of his tools. As he says in another part of the book, "most people one meets with in daily life can play at whist more or less—mostly less. There is whist and whist ; likewise there is homeopathy and homeopathy." The author is evidently past master in both.

THERAPEUTICS OF INFANCY AND CHILDHOOD. By A. JACOB, M. D., Clinical Professor of the Diseases of Children in the College of Physicians and Surgeons, etc., etc. Philadelphia : J. B. Lippincott Company. 1896.

Contrary to the general trend of the dominant school of medicine, which runs to bacteriocides and germ killers, this work is a contribution to therapeutics, for the author says : "Indeed, I believe in medicines. Advancing years and experience during a period of increasing exactness in medical methods have rather strengthened my belief than otherwise. What the knife is to the surgeon, drugs are to the physician ; both, however, are indispensable, to employ them with benefit takes skill and experience, both individual and collective, as also judgment and honesty."

These are refreshing words in these days of negation and doubt, where therapeusis mostly consists of serum injections, and, speaking of serum, the author calls attention to the fact generally overlooked, that as one attack of diphtheria predisposes to another, so the injection of serum, even if it granted temporary immunity, predisposes to a recurrence of the disease. The chapters upon hygiene and diet in infancy and childhood are particularly valuable.

A MANUAL OF ELECTRO-THERAPEUTICS FOR STUDENTS AND GENERAL PRACTITIONERS. By C. T. HOOD, A. M., M. D. Chicago : Gross & Delbridge Co. 1896.

"This manual on electricity has been prepared," the author says, "at the request of many students and practitioners who desire something on this subject that shall be concise and easily understood." With this object in view the author discusses what electricity is, the method of obtaining it, the construction and care of a battery, the physical and therapeutical use of the cur-

rent, its use in surgery, etc. The book is plainly and simply written so as to be readily understood, and will prove very useful to those who desire to study electricity the same as they would any other remedy and to apply it according to its indications.

PRINCIPLES OF SURGERY. By N. SENN, M. D., Ph. D., LL. D., Professor of Practice of Surgery and Clinical Surgery in Rush Medical College, Chicago; Professor of Surgery in the Chicago Polyclinic; Attending Surgeon to the Presbyterian Hospital; Surgeon-in-Chief to St. Joseph's Hospital; Ex-President American Surgical Association, etc., etc. Second Edition. Thoroughly Revised. Illustrated with 178 Wood-Engravings and Five (5) Colored Plates. Royal Octavo, Pages xvi+656. Extra Cloth, \$4.50 net; Sheep or Half-Russia, \$5.50 net. Philadelphia: The F. A. Davis Co., Publishers, 1914 and 1916 Cherry Street.

The rapid advance which has been made and is still being made in the science and art of surgery and in pathology is strikingly shown in the present edition of this work, which has been almost rewritten in order to keep pace with the progress made since its first appearance. Much new material has been added, a number of new subjects introduced, and more than fifty illustrations added. It is a work of great interest and value to every physician, whether an operating surgeon or not, as a knowledge of the principles of surgery are essential to the successful practice of medicine. The chapters upon inflammation and the reparative process are particularly valuable and will repay careful perusal.

THE AMERICAN YEAR-BOOK OF MEDICINE AND SURGERY. A Yearly Digest of Scientific Progress in all Branches of Medicine and Surgery. G. M. GOULD, M. D., General Editor. Philadelphia: W. B. Saunders. 1896.

The general design of this work has been to present in compact form an annual epitome of new and progressive medical truths which have appeared in journals, monographs, and text-books for the year ending with June, 1895. To successfully accomplish a task of this magnitude requires special skill and training, for, unfortunately, all that is new in medical publications is not necessarily true or valuable and the chaff is very much more abundant than the wheat. The general editor, Dr. Gould, is admirably fitted

for this kind of work, and with an able corps of assistants has given us a work that summarizes, and condenses into a shape for practical use, every item of value that has appeared in the journals or text-books during the year. The book is handsomely printed, profusely and finely illustrated with numerous woodcuts, half-tones, and colored plates, and should have a cordial welcome.

PEDIATRICS, THE HYGIENIC AND MEDICAL TREATMENT OF CHILDREN. By THOMAS MORGAN ROTCH, M. D., Professor of Diseases of Children, Harvard University. Philadelphia: J. B. Lippincott Company. 1896.

In this work the author begins with the consideration of the infant at birth, dwelling particularly and at some length upon normal development; following it through its various stages to puberty. Following the normal, abnormal conditions are discussed. In his classification of diseases the author has departed from the usual method, making no distinction between infectious and non-infectious diseases, for the reason that our knowledge of the former is increasing the number of the former class so rapidly that he no longer considers it a practical division for teaching. Beginning with the diseases which would naturally be met in the early periods of life, and devoting considerable space to observations upon the blood of infants and young children, the diseases of different organs are then considered. The illustrations, many of which are colored, are numerous and good, representing in nearly all instances cases occurring in the author's practice. In the treatment of the diseases of infancy Dr. Rotch places more reliance upon diet and hygiene than upon drugs, and has given much prominence to infant feeding—over 125 pages being devoted to that subject. A commendable feature of the book is the attempt to simplify the nomenclature of disease.

AN AMERICAN TEXT-BOOK OF OBSTETRICS FOR PRACTITIONERS AND STUDENTS. RICHARD C. NORRIS, M. D., Editor. ROBERT L. DICKINSON, M. D., Art Editor. With nearly 900 colored and half-tone illustrations. Philadelphia: W. B. Saunders. 1895 Price, Cloth, \$7.00; Sheep, \$8.00; Half-Russia, \$9.00. For sale by subscription only.

This magnificent volume, the latest issue of the American series, reflects the progress made in the theory and practice of obstet-

rics. With the advantages derived from the association of eminent authors, each treating the subject upon which he is an authority, it becomes at once a standard work upon the science and art of obstetrics, obstetric emergencies, the mechanics of normal and abnormal labor, and the various manifestations required in obstetric surgery are all clearly described. The numerous exquisite illustrations and diagrams assist materially in the elucidation of the text. The sections upon anatomy and embryology have been made particularly attractive and are illustrated by many elegant and eminently practical illustrations. A notable feature of the work is the attempt to systematize the illustrations: all figures drawn to scale; a uniform scale being adopted, usually one-third or one-sixth life size; in sagittal sections the same half is always shown for ease of comparison; and full labeling made directly on the drawing, which is given as much artistic treatment as is compatible with clearness and teaching quality.

The subject of the diseases of the fetus and newborn have been discussed more fully than is usual in works of obstetrics.

A PRACTICAL SYSTEM OF STUDYING THE GERMAN LANGUAGE.
For Physicians and Students. By ALBERT PICK, M. D., Newtonville, Mass. E. S. Tanner. 1894.

This practical manual for the study of German, which is published in twelve parts, at fifty cents a part, is an extremely simple and easy method for acquiring a knowledge of the German language by self-instruction. A few weeks' study, according to this system, will give a sufficient knowledge of the language to enable the student to read a medical article or to carry on a simple conversation in German. It will not make him a finished scholar, but will prove a key with which he may unlock the treasure of German medical lore.

HISTORY OF ANÆSTHESIA; OR PAINLESS SURGERY. By WILLIAM R. HAYDEN, M. D. New York: International Journal of Surgery. Price 25 cents.

A little volume, "written with an honest and unselfish desire to do justice to one whose inestimable services to humanity were persistently overshadowed by the most extraordinary perversion

of facts." If there be any doubt in the mind of the reader as he begins the perusal of this book, his convictions as to the real facts in the case will be quite clear at the end. Dr. Hayden has presented to the world all that is worthy of consideration in establishing the points at issue, and we do not see how any candid mind can undertake to controvert the statements published.

P. BLAKISTON, SON & CO., of Philadelphia, announce a book on "APPENDICITIS," by JOHN B. DEEVER, M. D., Assistant Professor of Applied Anatomy, University of Pennsylvania; Assistant Surgeon to the German Hospital, etc. The book will be arranged in a practical and systematic manner. The History, Ætiology, Symptoms, Diagnosis, Operative Treatment, Prognosis, and Complications of this disease will be given in the order named. It will contain about forty illustrations of methods of procedure in operating, and typical pathological conditions of the Appendix, the latter being printed in colors.

Materia Medica.

Chamomilla in Difficult Dentition.—Extreme restlessness. Patient wants to be carried all the time; irritability; sweating about the head; one cheek red.

Bryonia in Mastitis.—Pain in breast, sensitiveness to touch; aggravation by motion; great irritability; flashes of heat, alternated with shivering; great thirst; white tongue; dry, painful cough. Breast entirely well twenty-four hours after administration of the drug.

Trillium Pendulum.—Complete cure and normal course of pregnancy was effected by trillium pend. 1x, every five or ten minutes, in three cases of threatening abortion at the third and fifth month, with severe pains, profuse hemorrhage, and dilated os uteri. Trillium acts only in hemorrhage of gravidity well, but not in that of climaxis or unimpregnated uterus.

Benzoic Acid in Enuresis.—Dr. Evans.—Several cases have been reported in which young girls were cured by its use, some

of those having originated, and been continuous, since infancy ; and others where it had supervened upon some acute disease ; the dark, brownish, irritating, and exceedingly strong-smelling urine, characteristic of this drug, being the indication upon which it was successfully prescribed.

Cicuta Virosa in Infantile Convulsions.—Dr. Butler.—In head bent to one side, jerking and twitching of the head. Spasms of all muscles. Convulsions, with loss of consciousness, frightful distortions of the limbs and whole body. Convulsions with wonderful distortions of the limbs, head turned backward, back bent as in opisthotonos. Cramplike stiffness of the whole body, with coldness. She lies as if dead, with clenched jaws. Oppression of breathing. Staring ; she stares with unaltered look at one and the same place, and cannot help it.

Tanacetum for Epilepsy.—Dr. W. H. Pierson.—A woman took about a couple of drams of oil of tansy to produce abortion ; it failed, but throughout her pregnancy she suffered from convulsions, mixed tonic and clonic, characterized by frothing at the mouth and clenched hands with the thumbs in, and followed by exhaustion and a short coma. Since then I have treated every case of epilepsy in my practice with drop doses of fl. ex. tansy on sugar 4 t. d. with marked relief. One young woman has had no relapse for a year and a half and has been able to resume work—bookkeeping.

Glonoine in Headache and Amenorrhœa.—Dr. Murphy.—Miss C., age twenty-four, for five years had missed menstruating every summer and been subject, during the heated season, to intense headaches. Upon the return of cool weather she enjoyed the best of health. This headache awakened her at sunrise, grew worse until noon—making her frantic—then gradually ameliorated and at sunset disappeared until next day. The pain was in the temples and vertex, with throbbing and feeling as if the head would fall in pieces ; the pulse was full and hard, the temporal arteries raised like cords. Cured with glonoine. Note the effect on menstruation ; was it merely a coincidence ?

Pulsatilla in Vomiting of Pregnancy.—Dr. F. Elliott, Med. Cur.—Pulsatilla is especially useful where the stomach is con-

tracted and drawn upward, thereby pressing on the diaphragm and causing pain under the sternum. This is a condition frequently found and pulsatilla will always relieve it.

Such remedies as secale, caulophyllum, cimicifuga, and bryonia that are used where there is a rheumatic diathesis should never be given below the 12th, giving five drops on the tongue before rising. Other useful remedies are belladonna 2d, lobelia 1st, ipecac 1st, nux 3d, phosphoric acid 2d, mono bromo camphor 2d, cocaine 3d.

Mercurius in Abscess of the Labia Pudendi presents two varieties: Abscess of Bartholini's gland and deep abscess. P. Jousset gives the principal remedies as being mercurius, apis, and hepar sulphuris. Mercurius is the classical remedy. It is given at the beginning of the disease as the third trituration of mercurius solubilis. One dose every two or three hours. If mercurius does not stop the progress of the abscess, hepar sulphuris should be prescribed as soon as fluctuation is established. Apis mellifica is especially indicated in abscesses of Bartholini's gland. A few cures by this remedy have been cited. The abscess of Bartholini's gland often empties itself into the excreting canal. In other cases it is better to open the abscesses. This practice shortens the duration of the affection and usually stops the pain.

Sulphur in Coryza.—Dr. Hesse.—Sulphur has soreness of nose; ulcerations in the nose and chronic coryza all in the first rank. More important is the constant lying bare; in children this is a strong indication for sulphur. I never neglect in children to inquire for this symptom. However, we must ascertain that it occurs in winter in a cold room. This is the intolerance of the warmth of the bed of sulphur. Children can tolerate no bed-covering; always have their legs out, however often they may be covered. If the bedclothes are so fastened that they cannot get their legs out, their sleep is not so sound. Many times we find that after sulphur is given they will keep covered.

In adults we find an analagous symptom, viz.: burning of soles of feet or of the feet at night in bed, so that he must have them out of the bed-covers.

Lachesis in Melancholia.—Dr. McNeil.—Several years ago a lady called upon me, fifty-two years of age, of strong religious faith, very intelligent, and mother of a large family. Her domestic relations were very happy, and the only cause of her mental condition, a form of melancholia, seemed to be the loss of a grandchild who had died some time previously, after which she had been sick for a long time and lost a great deal of sleep. She made the statement that her menses were coming back, and, as we know, this is always a very suspicious symptom. Dr. Kellar made an examination, and came to the conclusion that incipient cancer was present. An operation upon the cervix, I believe, would have resulted in profound melancholia. She had periodical hemorrhages. The mental symptoms were great suspiciousness, especially of her own family. She thought her children were not treating her right. She wanted to live by herself, and yet thought her daughters were talking about her. She had loose morning stool and was troubled with terrible dreams. I could never get her to tell me what her dreams were about, but she would simply say that they were "disgusting." After a few trials of other remedies, I gave her *Lachesis*, which cured. This was six years ago. She has come twice in two years for more *Lachesis*. She was tottering between cancer and melancholia.

Symphoricarpus racemosa in Nausea and Vomiting of Pregnancy.—Dr. Haines, N. A. J.—Mrs. X., æt. thirty-eight. Blonde, stout, amiable, became pregnant with her second child October, 1893. Almost immediately suffered from nausea, to which was added within the month, vomiting whenever food was taken into the stomach. The only peculiarity noticed in her symptoms was the following modality: "As long as I am lying in bed, horizontal and perfectly quiet, I don't seem to feel the desire to vomit." Her appetite was diminished and occasionally there was repugnance to the sight of food or to the odor of it while it was being cooked. Remedies prescribed seemed to produce no amelioration. It was expected that after the fourth month of pregnancy was past, she would be free from the nausea and vomiting, but that period found her worse instead of better, confined to bed much of the time. When up and about her room nausea and vomiting were almost incessant. About this time—

while the family were discussing the propriety of inducing premature delivery—she was given *symphoricarpus racemosa* in the 2x dilution. Within a very few days there was complete relief—so complete indeed that the lady ceased taking the remedy. Then the symptoms returned and were promptly checked by the same prescription. Whenever the remedy was laid aside, nausea and vomiting reappeared, only to cease on resuming the medicine, and so she continued the remedy until full term of pregnancy was reached and she was delivered of a very healthy male child. The nausea and vomiting persisted, it will be noticed, the entire nine months, the *symphoricarpus* acted perfectly, as a palliative, allowing the patient to be up, out, and free from distress. The modality above mentioned is probably a true indication for *symphoricarpus* in nausea and vomiting of pregnancy.

Borax in Infantile Colic.—Dr. McLachlan, Med. Cent.—A baby, ten weeks old, had for some days been troubled with sudden screaming fits. They seemed to come on every ten or fifteen minutes, night and day. The baby would lie quietly for a time and then suddenly begin to scream and kick. During these attacks the face was red. It must be nursed and carried about constantly, but even then it would have the screaming attacks just the same. A day or two before this it had "white mouth," and had got a few doses of borax and honey, which very soon causes the "whiteness" to disappear. It was very easily startled by noises, etc., and they said it seemed to start as it was being laid into its crib. This last admission, however, was not voluntary, but only made after I had put "leading questions" about it, and therefore its value as a symptom was doubtful. I left *chamomilla* 30, but in case it should fail I sent two powders, No. 1, of *coloc.* 30, and No. 2, borax 30, with instructions that they were only to use the powders if what I left did no good, and should No. 1 relieve not to go on to No. 2. I called in a day or two, and was told that the medicine I left did no good, and that No. 1 powder (*coloc.*) was equally useless, but that after getting a dose or two of powder No. 2 (i. e., borax), it was not like the same baby. There had been no return of the colic. I suppose the colic was caused by the "white mouth going through" the child.

Trillium in Treatment of Fibroid Tumor of Uterus.—Dr. Huntley, Med. Times.—Mrs. D. L., aged thirty-three, had never been pregnant, but has suffered for a number of years from profuse and exhausting hemorrhages. Has noticed a tumor in the abdomen for five years, which has been diagnosed as fibroid, fibro-cystic, and ovarian tumor.

I was called to attend her August, 1894; found her nearly exsanguinated and suffering great pain, caused by the efforts of the uterus to expel its contents. The flooding had ceased temporarily. Examination revealed uterus prolapsed very low and fundus as large as a five months' pregnancy. I replaced the organ as well as I could, tamponed, and put her on trillium pendulum 3x, five drops in water every three hours.

No more hemorrhage occurred at this time, and but one attack since—now fifteen months under observation. I may state that the patient has taken the trillium three times a day in three drop doses ever since.

This patient was thoroughly examined when she had been taking the remedy one year. The tumor seemed to be smaller, cervix normal, and the patient is able to do her work all of the time, except two or three days at the menstrual epoch. I do not think she is cured, nor do I think the remedy capable of causing absorption of the growth, but the patient is comfortable and able to fill a useful position in life; and as long as operative interference is denied I am very well satisfied with the results.

Sulphur in Puerperal Fever and Septic Conditions.—Dr. J. Harmer Rile.—I desire to draw attention to the administration of a remedy which has NEVER failed me in septic conditions, no matter whether puerperal or purely surgical. The remedy is sulph. 200. There is no use in giving it lower, and you may go higher if you choose. I remember well the first time I had occasion to use it. The case had a temperature ranging from 103° to 105° for several days, and a friend advised me to give sulph. 200, saying that "your remedies are not reducing the temperature any, and you can't hope to have any lower temperature in the morning under any other remedy, and why not try sulph. 200 over night?" With many misgivings I did so, and was rejoiced to find a lower temperature in the morning, with less

offensive lochia, and the case went on from that time uninterruptedly to recovery. I have verified this use of sulph. 200 repeatedly. One case in hospital practice, which had continued for over three weeks with hot uterine douches of bichloride 1-6000, having a constant high temperature, was cured by sulph. c.m., four powders dry on the tongue; all douching was stopped and the four doses given at intervals of two hours, and sac. lac. thereafter; temperature dropped to almost normal in twenty-four hours, and within forty-eight hours to normal, and stayed so for nearly one week, when there was a slight rise again, sulph. c. m. being again administered, four powders, and the case recovered without any further medication. Experience has demonstrated these facts to my entire satisfaction. Where the absorption of septic matter has taken place, whether puerperal or otherwise, try sulphur, but don't give it less than 200.

Obstetrics.

"Meddlesome Midwifery"—A Dangerous Term.—Dr. Brady, Vir. Med. Month.—“Meddlesome midwifery” is a proper term for improper and unnecessary interference, simply this and nothing more. It is dwelt upon by gynecologists and obstetricians with dangerous, even if legitimate, emphasis, and improper deductions are drawn therefrom. Therefore, I state below what is considered the imperative duty of every physician and at every labor.

1. By observation and palpation, satisfy yourself that the patient is actually in labor.
2. Ascertain if bowels and bladder are empty; if not, empty them at once.
3. Make a digital and bimanual examination, and determine presentation, and relative size of head and birth canal.
4. If abnormal or difficult presentation, try to correct it.
5. Examine at regular intervals; if normal, to see that it stays so; if abnormal, to improve presentation if possible, and in either instance to note progress.

6. If, from failure of contractions, after dilatation of os, from great size of head, small size of pelvis, or other causes, delay seems dangerous, apply forceps.

7. Protect perineum ; and if necessary, retard extra rapid second stage.

8. Never allow the head to be retained long after delivery of body, in breech presentations.

9. Always examine placenta carefully, and if portions are, or even seem to be detached, go after them at once. Observe absolute cleanliness throughout.

All will agree on these points. Individually I approve of the use of chloroform to the degree of "obstetrical anæsthesia" in all cases, and also the skillful use of forceps in all difficult or delayed labors. Some differ on these points, however ; but on those tabulated, I believe that every man who has used the term "meddlesome midwifery" before our society will admit that they are essential, and their neglect is and must be due to either carelessness or ignorance, either of which is criminal in a properly qualified practitioner.

What is a "Natural Labor"?—Robert R. Rentoul.—I have taken some trouble to find in what way many practitioners have defined the term "natural labor"; the following are quoted : Churchill : "A natural labor is the delivery of a living child with safety to the mother, the vertex presenting." Simpson : "The head alone presenting, the labor terminated in twenty-four hours." Schroeder : "Normal parturition is the expulsion of the fetus at term from the uterus through the maternal passages by natural forces." Parvin : "When parturition is effected by the sole power of the natural organism." Spiegelberg : "From the point of view of frequency, the vertex presenting is the only normal labor ; all others are abnormal and must be considered as pathological occurrences." R. Barnes : "Eutocia (easy labor) is labor progressing smoothly, and terminating favorably under natural forces." Ramsbotham : "A case in which the head of the child presents, in which labor is completed within twenty-four hours from the commencement, and in which nothing of a dangerous or alarming

tendency supervenes throughout the whole conduct of the case." Hippocrates : "When the head or breech presents." Smellie : "A natural labor is one in which uterine action alone accomplishes delivery." Baudelocque : "All cases which are terminated by the natural powers." Davis : "Where the head presents." Blundell : "When the head presents, and the whole labor is terminated in twenty-four hours." Mauriceau : "Where the fetus is born living." Burns and Merriman : "Where the head presents, and the face is turned toward the sacrum." Cooper : "Labor terminated in twelve hours." Power : "Labor terminated in four hours." Conquest : "When the occipito-vertex presents, when there is sufficient room in the pelvis to admit of easy descent of the head : when the occiput emerges under the pubic arch, when no manual interference is needed, when labor is completed in a moderate time, and when the mother and infant are well. Cazeau and Tarnier : "The expulsion of the fetus by the efforts of Nature alone." Denman : "Every labor shall be called natural if the head of the child present, if the labor is completed within twenty-four hours, and if no artificial assistance be required." *Lexicon of Medicine* : "A labor which occurs at the end of the ninth month of pregnancy, the pains being regular and effective, the process not continuing beyond twenty-four hours, rarely more than twelve, and very generally not above six ; the size of the head and the capacity of the pelvis being duly proportioned, and no morbid state supervening either to prevent delivery or endanger the mother's life." Herman : "Labor is natural when the mother is in good health, and the pelvis is of not less than natural size ; when the child is living, and if not more than normal size ; when the vertex presents and the child's back is in front (sic) ; when the membranes do not rupture until the os is at least three-quarters of its full size (sic) ; when the placenta is implanted above the lower segment of the uterus, and is not detached until the child is born ; when uterine contraction and retraction go on at such a rate that the child is born within twenty-four hours from the beginning of labor pains, and continue after the child is born." C. V. Moore : "Natural labor might be defined ten days after delivery, not sooner."

The above and many more definitions show the absolute state of chaos which exists in our faculty as to what is a natural labor. It is to be feared we should show a very weak side of our glorious power to differ to the public if we appeared in a law court to give a judge and jury any "help" to arrive at a practical finding. This fear is not exaggerated when we remember that all the midwives' bills fixed the duty of the midwife to attend "natural" labor.

For the purpose of trying to arrive at a practical definition I would suggest the following as a definition of natural labor: Labor at the ninth calendar month in a woman free from organic and functional disease of the heart, lungs, kidneys, brain, and other internal organs, and from all fever diseases; when there is no impediment in the maternal passage, of either a soft or hard nature, to the passage of the child; where there is only one child in the womb; where the vertex of the child alone presents in either the first or second occipito-anterior position; where labor is completed within twelve hours from the commencement of labor; where a living child is born; where neither instrumental nor manual operations have been required; where the afterbirth comes away without the use of manual operation within twenty minutes after the birth of the child; where there is no laceration of any portion of the parturient structures; where the mother does not die within thirty-one days after confinement; and where there is no puerperal fever.

Spanish-American Accouchement.—Med. Fort.—The Mexican people are among the most peculiar in their observances of the proprieties at this critical period of their señóras' lives. It rarely happens that a physician is permitted to witness the confinement of a Mexican woman; the good offices of the Holy Virgin are thought sufficient at such times, and if death results, it is regarded as evidence of her displeasure, and not to be contended against. A very intelligent young mother, the wife of a cattle "Baron" in Southern Colorado, was called to visit one of the peon women, then eighteen hours in labor. The parturient, a primipara, was robed in a scarlet gown, a green bow at the neck, and a crown of "cheese cloth," the end of which flowed down

the back like a bridal veil, and a wreath of red artificial flowers was worn on the head. This dress is worn in supposed imitation of the Holy Virgin's attire, while giving birth to the Saviour.

In one small room there were eight men, including the unmarried man, who served as the accouchement chair, several women, besides uncounted children, dogs and young chickens, all interested in or disturbed by the occasion. As the pains grew stronger, the patient swore, shrieked, and prayed alternately under the greatest excitement, stopping only to drink mescal or eat meat, with which she was constantly supplied. After many prayers had been offered by the sympathizers without tangible results, the "chair" seized his charge in the axillas, and shook the delayed heir into the world without more ceremony, to the intense relief of all present, the American lady excepted. A gun was discharged immediately, three times, as a signal for all within hearing to kneel and thank the Virgin for her assistance. The child was then secured; the placental end of the cord tied to the mother's leg to prevent its disappearance, and the mother left to rest on the earthen floor.

At the end of some hours, the placenta having failed to come away, a cord was tightly tied around the waist and a burnt rag forced into the throat to provoke emesis. These expedients failed and the white woman was again called, and promptly removed it. The child was put in charge of another woman with a young babe until the mother's lacteal secretion should be established. When this occurred she refused to suckle it, because of the pain; mammary abscesses followed, which were treated by corn meal poultices made thin and allowed to dry, but the mother escaped that dreaded of all obstetricians, puerperal infection, a rare complication among these people.

Application of Forceps in Occipito-Posterior Cases.—Professor S. Tarnier (Journal de Paris) points out that spontaneous delivery may take place in one of two ways when the occiput is posterior: In one case the occiput undergoes a long rotation forward so that an occipito-posterior is converted into an occipito-anterior case; in the other the occiput remains behind in the hollow of the sacrum, and if the perineum is yielding and the

pains strong the head is delivered in this position, the posterior fontanelle being the first part of the child's head to be born. Supposing that the occiput does not rotate forward, and the head does not advance, an attempt should be made to rotate it forward with the hand, and this can often be accomplished because the head still remains movable. If the occiput is to the right the left hand is introduced and the head seized, the thumb being placed behind the ear. The head is then rotated from right to left and from behind forward, and the hand retained in position, because otherwise the occiput will again turn backward owing to the fact that the shoulders have not rotated forward with the head. The right blade of the forceps should now be introduced, and after being placed in position is entrusted to an assistant to hold. By this means, when the left hand is withdrawn, the head is still retained in place. The left blade is then applied and the blades locked. On making traction further rotation takes place as the head descends. When the occiput cannot be rotated forward by the hand he recommends the following plan : The blades of the forceps are applied in one of the oblique diameters of the pelvis ; so that if the occiput looks to the right sacro-iliac synchondrosis the left blade is opposite the left sacro-iliac synchondrosis and the right one opposite the right obturator foramen. When the forceps are in position the first thing to do is to flex the head, and this can often be accomplished by pulling on the traction rods. If in spite of this traction the posterior fontanelle still remains high up and difficult to reach, the hands of the forceps should be carried forward, at the same time that the traction is maintained on the crossbars. The head will thus be flexed, and the next thing to do is to aid rotation. This can be done by making the handles of the forceps describe a wide arc of a circle while traction is being made. The occiput having thus been rotated forward, it will be seen that the concavity of the forceps now looks toward the hollow of the sacrum. If the perineum is resistant it is best either to take off the forceps and reapply them, or to allow the head to be expelled by the uterine pains after the blades are removed. If the pains are inefficient, a maneuver described by Ritgen may be employed, which consists in introducing a finger into the rectum and pressing on the fore-

head. In some cases, according to Tarnier, it is not necessary to remove the forceps, and by carrying the traction rods upward and forward, the danger of cutting the perineum with the points of the forceps is obviated. He concludes by alluding to the fact that the maneuver which is in France associated with the name of Ritgen was really first described by Smellie.

Funis Coiled Eight Times Round Fetus.—Wygodzky (Centralbl. f. Gynäk.) finds that the greatest number of coils of the umbilical cord ever found to encircle a fetus are seven (Baudelocque), eight (Credé), and nine (Müller and Gray). His own case was observed this year in Wilna. The patient was a primipara, aged twenty. The last period was seen on May 10, 1894. On February 19, the fetal movements suddenly ceased. On the 20th pains set in, about two weeks before term. At noon turbid liquor amnii escaped. At 2 P. M., on examination, Wygodzky defined a dead fetus in left occipito-anterior presentation, in the inlet, very high. The os was nearly completely dilated, the pains strong. By 4 P. M. the head was hardly engaged in the pelvic cavity. At 7 P. M. it neared the outlet at the height of each pain, but retracted immediately afterward. After 10 P. M. the pains grew weak. At midnight Wygodzky delivered the dead child by expression. Not till then was the cause of delay clear. The funis was very tense and coiled seven times round the neck and once round the left shoulder; there was also a distinct knot. It measured over sixty-five inches in length. The fetus was a male, slightly macerated. It weighed over five pounds, and was easily delivered entire after division and unwinding of the funis. No marks remained on the neck. The placenta followed ten minutes later, and, as far as naked eye experience could indicate, it seemed healthy.

Pregnancy and Smallpox.—Van der Willigen (Nederland. Tijdschr. voor Geneesk.), in closely observing 432 cases of smallpox in women under fifty, made particular note of 80 who were pregnant. Of these 15 per cent. died, while the mortality of the non-pregnant cases was 11.08 per cent. Van der Willigen, like some previous authorities, finds that pregnancy increases the predisposition of a patient to the graver forms of variola. In the 80

cases, confluent smallpox was seen in 4 and hemorrhagic in 6 cases; all the 10 died. In the 352 non-pregnant cases the confluent form was observed in 3 and the hemorrhagic in 11 patients; 2 of the confluent cases recovered. Two pregnant women died of milder forms; of the total, 12 there died 5 undelivered, and most of the others very shortly after birth without any trace of puerperal infection. Of the primipara, 9 per cent. died, of the multipara, 17.25 per cent. 6.25 per cent. of women attacked by smallpox early in pregnancy died, while the mortality of those who were infected later amounted to 20.83 per cent. Abortion or premature delivery was noted in 23 of the 80 cases during the course of the attack of smallpox. In 6 the same took place after convalescence from the disease: 16 children were delivered alive in cases where the smallpox was still in progress, 8 at term, and 8 prematurely; only 3 lived longer than six months. Several died of variola; 2 were clearly born with it.

The Uterus in Ectopic Gestation.—Pilliet, in the Brit. Med. Jour., has studied the histology of the modifications which the uterus undergoes in tubal gestation. He finds that the development of a decidua in its empty cavity during ectopic pregnancy is more than a pathological phenomenon; it is a distinct clinical complication. As long as the decidua remains in place the uterus is practically in a condition of subinvolution; hence both hemorrhages and membranous dysmenorrhea may occur. When the decidua has been shed there is danger of diffusion of metritis to the whole uterine muscle. Pilliet adds rather significantly that the ætiology and pathology of endometritis are both obscure, and that probably ectopic gestation, overlooked in its early stages, may account for many peculiarities in cases of endometritis hitherto hard to explain.

Missed Labor.—Stahl (Der Frauenarzt) relates a case in which he feels sure that labor was missed, and where he afterward induced a kind of secondary "premature labor," as he terms it—or, in more usual terms, he delivered a fetus which the uterus refused to expel. The patient was intelligent. Her pelvis was contracted by prominence of the sacrum. Three labors had been normal, and only lasted some two hours each; a fourth had

been more lingering, and a very big child was delivered at term. Labor pains, very distinct, set in at term in the fifth pregnancy. For three hours the uterine contractions were strong and regular, then the intervals grew longer and the pains weaker till they ceased. When 302 days had elapsed after the last period, Stahl found the patient inconvenienced by the great size of the abdomen, so he turned and delivered a very well-developed fetus, which was alive at the beginning of the delivery. The prominent sacrum gave great trouble; the perineum was badly torn owing to the great size of the fetal head; ossification of the cranial bones had advanced very far, and made the parts incompressible. The fetus weighed 12 lbs. 8 oz., the placenta and membranes 2 lbs. The measurements of its head were: circumference, 16 in.; occipito-frontal diameter, 5.8 in.; bi-parietal, 5.2 in.; bi-temporal, 4.6 in. The perineum and the rent—nearly an inch long—in the rectum were sewn up at once, and the mother made a good recovery. No uterine disease nor rectal trouble ensued.

Gynecological Etchings.

A Mode of More Easily and Rapidly Dilating the Cervix of the Unimpregnated Uterus.—Dr. James Braithwaite, Brit. Med. Jour.—Dilatation of the unimpregnated uterus is necessary chiefly for two purposes, namely, for the treatment of certain cases of dysmenorrhea, and in order to examine the uterine cavity with the finger for diagnostic purposes.

The os internum between the periods firmly resists dilatation, and only yields to considerable force.

Many years ago I found out accidentally that if the dilatation is done on the last day of the period, just when the discharge has ceased, the parts are perfectly elastic and soft, and have very little resisting power. Hegar's dilators can, in many cases, be passed in, one after the other, until No. 17 is reached. This admits of the passage of a medium-sized index finger. An anæsthetic is necessary, as the patient would not remain sufficiently quiet. Two Sims' hooks close together, so that the handles are

held as one, are better than a vulsellum. They hold better, and are less likely to scratch the operator's finger. The process should be done leisurely, but it does not take above twenty minutes. The smaller sizes of the dilators should have the terminal inch a little curved forward and less in size, so as to enter more readily.

This plan opens up quite a vista of utility in other cases than those of dysmenorrhea; for instance, it is often next to impossible to examine with the finger the interior of the uterus of a sterile woman over forty. The parts absolutely refuse to dilate sufficiently. But by dilating on the last day of the period it can be done very easily. Every uterus does not yield so readily, and, indeed, now and then a tough cartilaginous os internum is met with which almost refuses to yield at all, but even this is more dilatable than it would be in the intermenstrual interval.

A very interesting case of menorrhagia was recorded some years ago which had been under two of the most eminent men in the country, and in which subsequently the womb was removed entire on the Continent. It was then found that the cause of the hemorrhage had been a small fibroid not as large as a marble. This had never been diagnosed.

Another case was read before one of the London societies, in which vaginal hysterectomy was performed in consequence of incurable hemorrhage. It was thought to be cancer of the uterine cavity; but on examination of the uterus after removal, the cause was found to be a small fibroid polypus projecting into the cavity near one cornu. In these cases, if the finger could have been inserted for examination, no doubt it would have been.

By adopting the plan recommended, such examinations become easier, although such small fibroids and so situated as in these two cases must always be very difficult to diagnose. Much assistance is given by curving the intra-uterine finger well forward and pressing the fundus down upon it by the right hand outside. For this purpose the patient should lie on her left side, as the recti muscles are thereby relaxed. It might be supposed that the anæsthetic would cause sufficient relaxation; but it often does not.

In conclusion, the advantages of the plan recommended are:

1. Danger from sepsis by the use of tents is avoided.

2. Inflammation, if rise of temperature with rigors and much pain indicate it,—traumatic rather than septic,—is also avoided.

3. The process, both to patient and operator, is more easy, and is incomparably quicker.

4. Less structural injury is done to the parts, as they dilate more kindly and without much resistance.

5. The dilatation is more complete and perfect, so that if used for dysmenorrhea a permanent cure is more likely to result, and if for diagnostic purposes, examination is possible in cases in which otherwise it would have been impossible.

Imperforate Hymen; Imperforate Os Uteri; Hæmato-metra; Hysterectomy.—Dr. Murphy.—Mrs. G., aged forty-two, married twenty-five years, had never menstruated nor suffered from any periodical troubles. She had enjoyed fairly good health till four months previously to my seeing her, when she was found to be suffering a good deal of pain in the lower portion of her abdomen on the right side, and was losing flesh. On admission into the infirmary a large fluctuating tumor could be felt extending an inch or two above the umbilicus, and situated principally on the right side. On introducing the finger between the labia, a cul-de-sac could be entered for two or three inches, beyond which no tumor could be found. By passing the fingers into the rectum, no tumor could be found, or any traces of a uterus, but the cul-de-sac could be inverted and protruded through the labia as one can turn out his trousers pocket. Abdominal section was performed, and a tumor was discovered covered by a thick layer of peritoneum, and of a grayish color. The introduction of a trocar allowed the escape of some ten ounces of brown serum. On enlarging the wound, a large mass of organized blood clot was removed, and the uterus, for such it was, was then shelled out of what appeared to be the broad ligament, and was ligatured at its base by a silk ligature and removed. The broad ligament was then sutured to the abdominal wound, and as there was free hemorrhage, it was plugged with iodoform gauze. The patient made an uninterruptedly good recovery.

This was apparently a case of imperforate hymen where the husband's energy, although not sufficient to rupture the hymen,

was in the course of a quarter of a century equal to stretching it to the extent of two or three inches. The patient also appears to have had complete atresia of the os uteri, but the curious point is that the womb seems to have hibernated till its owner reached the age at which most wombs become dormant, and then it seems to have realized its duties, with the results that I have related.

This patient had to be readmitted into the infirmary four months after the operation as the abdomen had become very much distended and she was suffering very severe pain. On opening the abdomen, it was found to be full of organized blood clot, all trace of the marsupialization of the broad ligament had disappeared, and the stump of the cervix appeared in its normal position and on each side a fairly normal ovary. The clot (some sixty ounces) was cleared out and no bleeding point could be discovered, and the abdomen was washed and closed. She left the infirmary quite well in three weeks, but in a few weeks more she again began to swell, the swelling increased enormously and eventually burst open the cicatrix, and for some days a brown serous fluid escaped, and then she died, having in a most positive manner refused all treatment, and to the regret of Dr. Morton and myself no *post-mortem* examination of the body could be obtained.

Remedies for Leucorrhœa.—This troublesome disorder requires not only the appropriate internal medication, but also local antiseptic treatment. Nothing in my experience has ever been so effective as hydrozone, which, while a powerful antiseptic, has, by its stimulating and healing action upon the diseased mucous membrane of the vagina, a prompt and curative effect.

Copious injections should be administered at least twice daily, by means of either a glass or hard rubber syringe with a mixture of one to four ounces of hydrozone with two pints of lukewarm water, the proportion to accord with the tenderness of the infected surface.

Normal Range of Germs in the Genital Canal.—Sdroganoff (Centralbl. f. Gynäk.) has conducted a series of bacteriological experiments in the Clinical Institute, Helena Pavlovna Hospital, St. Petersburg. Specimens of mucus from the higher and lower parts of the vagina and uterus were removed, with every precau-

tion, in test tubes, and carefully examined. He finds that not only is the canal of the cervix sterile as a rule in pregnant and non-pregnant subjects, but its mucus is actually fatal to bacteria. The os externum marks the limit between the germ inhabited and germ-free districts of the genital canal.

Significance of Vaginal Discharges.—S. C. Mish.—A leucorrhœa inodorous, or of mild odor, persisting during the climacteric, accompanied by increasing hemorrhage, is suspicious, and demands investigation.

A leucorrhœa profuse, of peculiarly fetid odor, grumous, exco-riating, appearing early or late during the climacteric, with profuse hemorrhage, is reasonable evidence of cancer of the cervix.

A leucorrhœa, moderate in amount, illsmelling (the peculiarly fetid odor of cancer of the cervix being absent), accompanied by hemorrhage, suggests cancer of the corpus uteri.

A leucorrhœal discharge with hemorrhage, containing material like the washings of meat, is said to indicate sarcoma.

A watery discharge, as a rule, occurring during menstruation, odorless or of little odor, persisting, accompanied by profuse hemorrhage, indicates fibroids; with little or no hemorrhage, polypi.

Profuse bloody discharges coming on gradually with declining menstruation, ceasing usually with the menstrual flow, point to fibroids.

Persistent profuse discharges of blood occurring spontaneously, arising from sudden exercise or coition, occurring, as a rule, after the menopause, indicate cancer.

Wounds of Vulva from Falling Astride.—Taffier and Lévi (Sem. Méd.) have prepared an instructive article on this subject illustrated by drawings of dissections of the vulvar relations when the subject is erect. The urethra is rarely injured. The bulb and surrounding venous plexuses are often torn and bleed very freely. Not rarely the skin and mucosa remain intact. Then a thrombus forms which may burst or harden, or suppurate or end by becoming a cyst. Skin wounds inflicted by a sharp object on which a woman falls astride seldom run from without inward. More often the inner side of the vulva is wounded and the hard

ramus of the ischium prevents retraction of soft parts, hence dangerous hemorrhage may occur. It is, however, generally venous. To check hemorrhage, firm pressure is unsuited on account of the extreme tenderness of the parts. Compression by antiseptic gauze is the best way to stop the bleeding. Indeed, as recurrence is very common, it is best always to compress a contused wound. The thighs must be tied together and a catheter retained or frequently passed.

Pseudocyesis—Spurious Pregnancy.—S. Weir Mitchell, Med. News.—A woman, young, or it may be at or past the climacteric, eagerly desires a child, or is horribly afraid of becoming pregnant. The menses become slight in amount, irregular, and at last cease or not. Meanwhile the abdomen and breasts enlarge, owing to rapid taking on of fat, and this is far less visible elsewhere. There comes with this excess of fat, the most profound conviction of the fact of pregnancy. By and by the child is felt, the physician takes it for granted, and this goes on until the great diagnostician, Time, corrects the delusion. Then the fat disappears with remarkable speed, and the reign of this singular simulation is at an end.

Some time ago I was consulted by a lady, in regard to a woman of thirty years of age, a nurse in whom she was interested. This person had been married some three years to a very old man possessed of a very considerable estate. He died, leaving his wife her legal share and the rest to distant cousins, unless the wife had a child. For two months before he died the woman, who was very anæmic, ceased to menstruate. She became sure that she was pregnant, and thereupon took on flesh at a rate and in a way which seemed to justify her belief. Her breasts and abdomen were the chief seats of this overgrowth. The menses did not return, her pallor increased; the child was felt, and every preparation made for delivery. At the eighth month a physician made an examination, and assured her of the absence of pregnancy. A second medical opinion confirmed the first, and the tenth month found her an immense size, and still positive as to her condition. At the twelfth month her menstrual flow returned, and she became sure it was the early signal of labor. When it passed over she became convinced of her error, and at once

dropped weight at the rate of half a pound a day, despite every effort to limit the rate of this remarkable loss. At the end of two months she had parted with fifty pounds and was on the whole less anæmic. At this stage I was consulted by letter, as the woman had become exceedingly hysterical. This briefly stated case is a fair illustration of my thesis.

Another instance I saw when in general practice. A lady who had several children and suffered much in her pregnancies, passed five years without becoming impregnated. Then she missed a period, and had, as usual, vomiting. She made some wild efforts to end her supposed pregnancy, and failing, accepted her fate. The menses returned at the ninth month, and were presumed to mean labor. Meanwhile she vomited up to the eighth month, and ate little. Nevertheless, she took on fat so as to make the abdomen and breasts immense, and to excite unusual attention.

No physician examined her until the supposed labor began, when, of course, the truth came out. She was pleased not to have another child, and in her case, as in all the others known to me, the fat lessened as soon as the mind was satisfied as to the non-existence of pregnancy. As I now recall the facts, this woman was not more than two months in getting rid of the excess of adipose tissue.

Dr. Hirst tells me he has met with cases of women taking on fat with cessation of the menses, and in which there was also a steady belief in the existence of pregnancy. He has not so followed up these cases as to know if in them the fat fell away with speed, when once the patient was assured that no child existed within her. My much-regretted friend, Goodell, promised the detailed account of at least two examples, having precisely the sequence of symptoms I have described.

These women are in no sense of unsound mind, nor is their illusion to be classified with the delusory and obstinate belief as to their pregnancy held by some of the insane. These latter persons may be virgins or not. Sometimes the idea has arisen in connection with uterine symptoms, or else is the outcome of some exposure to the creation of pregnancy and alarm at a possible, but non-existent pregnancy. Many of these people hold to the notion for years. Dr. Hirst recalls to me the story of Dupuy-

tren, who, when consulted for such a case of eighteen years duration, advised the woman to swallow a private tutor. It is said to have cured the case, which I much doubt. I knew of one instance in which a physician etherized such a case, and assured the woman he had taken away a dead child. This answered for a week, and then she confided to him her regret that he had not taken away the other, as now she knew they were twins.

The delusion of pregnancy in the insane is neither created nor kept up of need by excess of flesh or failure of menstruation. No such food for fancy is needed. It defies the contradictions of time and the popular knowledge of physiology.

The illusion of the patients I describe is inevitably destroyed by time and adverse circumstances.

I can find no mention anywhere in literature of cases like those I have described. Perhaps I may have overlooked them, or they might be found on more careful search. Yet, after inquiry of men with the large experience of Goodell and Duer, I am forced to believe them exceptionally rare.

A woman who is emotionally eager to have or not to have a child; one with the unsatisfied craving for motherhood, or one who has been fearfully tormented in her pregnancies—these, I think, are the classes of women liable to this complex group of symptoms. More rarely it is a woman long childless, who somewhat early and suddenly ceases to flow, and, as is not rare at the climacteric, puts on flesh very rapidly. The illusion of pregnancy is in such females a flattering one.

The other cases are the more interesting. The woman has naturally and too constantly dwelt, with disappointed hope or abiding fear, on the loss or delay of the periodic bleeding. Then she becomes more gladly sure or more alarmed, as the case may be, as she gains flesh, and especially abdominal fat. Is this gain in flesh an accident of nutrition which combines, with lessened or absent menstruation, to give and sustain her growing illusion as to pregnancy? Women, as I long ago remarked in my book on "Rest Treatment," are easier to fatten than men; also in them gain or loss of adipose tissue is more common than in the other sex, and less significant as to health or of pathologic disaster. The point as to which I remain in doubt is, as to whether belief in

the presence of the pregnant condition in any way influences the really singular gain in fat seen in certain of these cases. Whether it is, as I said, coincident and assistant of belief, or whether it follows that mental state, I do not know. Some women thus deluded are, when once assured of pregnancy, likely to be careful to exercise less than usual, and acquire, like some pregnant women, excessive appetites. Also it is quite sure that once they are convinced of their delusion they lose flesh very speedily, and this, too, may be in a measure due to a return to normal habits. Still there remains for us the unsolved problem of how much the mind has to do with the gain and loss of weight. The first of these cases I ever saw was brought to my knowledge in a singular way: A woman had given birth to two female children. Some years passed, and her desire for a boy was ungratified. Then she missed her flow once, and had thrice after this, as always took place with her when pregnant, a very small but regular loss. At the second morning vomiting came on as usual with her. Meanwhile she became very fat, and as the growth was largely, in fact excessively, abdominal, she became easily sure of her condition. She was not my patient, but her husband consulted me as to his own morning sickness, which came on with the first occurrence of this sign in his wife, as had been the case twice before in her former pregnancies. I advised him to leave home, and this proved effectual. I learned later that the woman continued to gain flesh and be sick every morning until the seventh month. Then menstruation returned, an examination was made, and when sure that there was no possibility of her being pregnant she began to lose flesh, and within a few months regained her usual size.

Pediatrics.

Intussusception in Infants.—Dr. Crandall, Arch. Ped.—Intestinal obstruction in infants is almost always due to intussusception. The symptoms, frequently obscure at the outset, usually become distinctive as the lesion progresses. There is violent pain,

at first spasmodic ; vomiting, frequently persistent ; obstinate constipation, with a discharge of mucus and blood from the rectum ; and tenesmus, which, with the discharge of mucus and blood, may lead the unwary into a diagnosis of dysentery. On palpation of the abdomen a tumor will be discovered, usually on the left side. The mass, with the ileo-cæcal valve at its apex, may commonly be felt at the rectum, and not infrequently it actually protrudes. In the treatment of intussusception, drugs, except opium, are either useless or dangerous. A cathartic should not be used under any consideration, when there is even a suspicion of this condition. If one has been administered before the diagnosis has been made, its action should be checked as far as possible by the free use of opium. Opium in small doses, by relieving pain, may prove in the early stages of the greatest service. The chief objection to its use is the danger that it will mask the symptoms, and the attendants will be led to the false belief that the patient is improving. Attempts at reduction should be made only by injections of warm water, given with a fountain syringe. The bulb syringe is a dangerous instrument here, for with it a man may easily apply a pressure of 90 pounds to the square inch—a force sufficient to rupture the intestine. The normal intestine, it has been found by Forest of New York, will sustain without injury a pressure of 6 pounds to the square inch. With the fountain syringe, the pressure can be regulated by proper elevation of the bag, each $2\frac{3}{4}$ feet in height adding 1 pound pressure to the square inch. The bag of the syringe may, therefore, be safely raised 12 feet above the patient. In giving the injection, the child is anesthetized and the hips are elevated. A large-sized tube is used, and the rectum is occluded by means of a bandage wound about the tip in the shape of a cone. The pressure, graded by the elevation of the bag, should be steadily applied for thirty minutes. The greatest gentleness should be observed throughout. Should these measures fail when conscientiously carried out, laparotomy should be performed, although the results of this operation in this condition have not, on the whole, been encouraging.

Pernicious Anæmia in Children.—Dr. Baginsky reports two cases of pernicious anæmia in children aged respectively 10 and $3\frac{1}{2}$ years. The examination of the blood proved beyond doubt

the nature of the disease, and both children succumbed quickly. Although a few cases had already been published, he thought that if we were more accustomed to examining the blood microscopically, we should find that such cases were more common than was generally supposed. The bacterium coli was found in the blood, and it was an interesting question whether it had any connection with the disease. There was no history of syphilis in either case.

The Offspring of Young Mothers.—At the Congress of Hygiene, Dr. Korosi, of Buda Pesth, stated that the proportion of deaths among children from weakly constitutions, or maladies traceable to the mother, was twice as large among the children of mothers under twenty as among the children of mothers over thirty, upon a comparison of several thousand cases.

Treatment of Pediculosis Vestimentorum.—Allan Jamieson, Brit. Jour. Derm., says that in pediculosis corporis no remedy acts so promptly and efficaciously as petroleum, but there is an awkwardness in applying it to the general surface of the body. Incorporated in a soap such as Calvert's "petrofenic" soap, which contains carbolic acid as well as paraffin oil, it can be employed to wash the skin, the lather being allowed to dry on. In this way the eggs which are sometimes attached to the downy hairs are killed. The insects themselves live in the body clothes, and deposit most of their ova there. Treatment must, therefore, be perseveringly directed against them. This can be accomplished by taking advantage of the property of sulphur of slowly subliming and becoming oxidized into sulphurous acid at the temperature of the body. A piece of roll sulphur, the size of a pigeon's or bantam's egg, is inclosed in a porous bag made of muslin or canvas, and worn next the skin day and night. The sulphurous fumes imperceptibly impregnate the clothes, and render them unsuitable for the existence of the parasites. Patients can thus be freed from a source of annoyance, or the accuracy of a suspicion can be tested without their being taken into the practitioner's confidence as to the cause of their trouble. The plan suggested has proved of service to the author in several instances.

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EDITOR, B. F. UNDERWOOD, M. D.,
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CIMICIFUGA RACEMOSA IN PUERPERAL CONDITIONS.

BY

JOHN C. SANDERS, M. D., LL. D.

THERE are very few remedies in the entire materia medica more commonly indicated in the morbid conditions possible to the puerperal state than is the one that I have chosen as the subject of my brief paper, namely, *cimicifuga racemosa*, or, as more commonly designated, *macrotis*, or *macrotine*, which is but the resinous extract.

We will consider its applicability to the three puerperal conditions respectively: A. The gestative state. B. The parturient state. C. The lying-in state; and in their order.

A. The gestative state.—In the progression of gestation there may, and often do, arise symptoms strongly demanding this remedy. These may be grouped under four distinct heads:

First. Headache. The headache of *cimicifuga* is very distressful, and quite characteristic. It is not congestive

or inflammatory, but neurotic. It is not pronouncedly a frontal headache, but a coronal and occipital headache, and especially the *latter*, and creeps down, as if implicating the medulla oblongata as its radiating center. From this point, as a center, it creeps up to the occiput and over the crown, and reaches down into the temples, especially the left. It is always relieved by the open, out-door air. This is a macrotine headache, and especially so when it is associated with nausea of the stomach, with or without vomiting, for nausea or vomiting, sooner or later, is an attendant on this type of headache. This character of gestative headache may be very distressful, and may persist through the period of twenty-four hours, with scarcely any abatement, and may require several days for the patient to rally from its sufferings and depression and shock. If its character is clearly made out, it may be well-nigh infallibly relieved by the administration of this remedy, in proper potency.

Second. The second group is made up of a class of so-called dyspeptic symptoms, common to the gestative state.

So far as my experience has reached, it exerts no marked control over the so-called morning nausea or the nausea and vomiting of gestation. In the treatment of this malady I never have been able to obtain, in any potency, from this remedy any satisfactory results. And yet the remedy is relieving to many of the slighter, yet annoying, conditions of the gastro-enteric tract that often wait upon the gestative state. These are faintness of the stomach, and sensation of emptiness; transient nausea occurring at any time, and capriciously; loss of all appetite, and, at times, absolute repugnance to all food; pain, and regurgitation of food after eating; flatulency and distressful fullness, especially around the umbilicus and through the lower abdomen; dull, griping pain centered around the umbilicus, taking on a periodic character.

Third. The third group of symptoms is made up of the

distressful back and limbs ache which often afflict the gestative state. Few women escape, especially, this distressful backache, which is generally centered right across the lower lumbar and sacral tract. This is predominantly relieved by rest, and aggravated by motion. This distress sometimes extends down the thighs, one or both, taking, generally, the sciatic tract for its course. The source of this distinctive suffering, beyond doubt, is the lumbo-sacral and sacral plexus of nerves, and is reflex in its character, and from some irritated uterine nerve filament. There is hardly another remedy so broadly and specifically indicated, or so generally relieving of this group of symptoms, as the remedy under discussion, in one or another of its potencies.

Fourth. The fourth group is the uterine myalgias so common to the gestative condition.

The uterine walls, in the progression of gestation, are just as liable to myalgic suffering as any other muscular tissue, and this myalgic suffering is predominantly of a rheumatic type. The distress is as much made up of soreness as of pain. This may be limited to some one area of muscle wall, central or at either side, or may extend and involve the entire uterine front, and form its fundus to its cervical limit. From the out-lift of the garments worn for the protection of the lower part of the body incident to the projecting abdomen, especially in the later months of gestation. This disposes the woman to chill, a chill of the lower abdomen, and such chill is very provocative of this form of suffering, and may lead, and sometimes does, right on to a local or general myalgia, with abortive complications and dangers. The neuralgic form of distress, resulting from such provocation, fortunately predominates. This may be temporary, continuing only for a few days, but it is prone to persist for a long time, nearly, and even to the time of labor, and may enter as a factor in the ensuing after-pains. While there are many remedies that hold a symptomatic relation to this particular group of suffering, I have found

no remedy having a more general applicability, or greater capability of relief, than *cimicifuga*.

In my early experience with this remedy, I felt not a little timidity as to its use in gestative conditions, by reason of its reputed power as a parturifacient, but I am now satisfied it is innocent of all harmfulness, surely so in any potency possible to a true homeopathic prescription.

Besides these four groups of morbid phenomena, there is a possible condition in gestation, not declared by any gestative symptom, which forcibly appeals for the ministry of this remedy. This condition hardly admits of a definition, and yet may be designated an idiosyncrasy, an exceptional individuality, a habit of predisposition to hemorrhagic labors. The predisposition is of unquestioned heredity, and reaches down from one generation to another.

By virtue of the power which *cimicifuga* is capable of exerting over the uterine forces, I am convinced that it is entitled to the first place as a prophylactic to this hereditary hemorrhagic habit. To wield this prophylactic power most efficiently and surely, it should be administered during the latter months of the gestative period, say, from the completed sixth month on up to the time of, and during, labor. My experience is, and counsel would be, to give the remedy once daily, during the seventh month, twice daily during the eighth month, and four times daily thereafter until the time of declared labor; and during labor every two or three hours, unless some other remedy should be more symptomatically indicated.

B. Parturient state.—The power possible in this remedy of promoting and conceiving normality of the uterine energies, has given it a popular fame as unfailing indicative of easy labors. Whether this popular fame is warranted by the experiences of the profession, or not, is still an undetermined question. For one, I have never been able to witness any special *ease* of labor secured by the administration of this remedy, whether from its popu-

lar use, or its use under my own ministry. I doubt seriously its possession of any *easing* power over the labor process, beyond its unquestioned capability of promoting and conserving normality of the uterine forces. With all its possible conservation, the Biblical decree upon woman still abides: "In sorrow shalt thou bring forth children."

Conceding to *cimicifuga* only this, namely, that it is capable of producing normality of the uterine forces, it stands forth as worthy of a high place in the therapia of the labor process. The especial adaptations are to the order of preternatural labors, denominated "tedious," and to the following types:

First. Where there is lack of co-ordination of the uterine contractions. Second. Where these contractions are substituted by pains elsewhere, as upon the stomach in form of severe gastralgia, or upon the bowel sheath in form of colic, or upon the brain in form of an aphalgia, or upon the lumbar and sacral tract as in agonizing lumbar and sacral pains. Third. Where the pains, though normally located, are feeble and inefficient, and this independent of uterine weariness or exhaustion or mental shock. I have been witness to the prompt and efficient helpfulness of this remedy in many cases bearing these symptomatic indications, both in the first and second stage of labor. If there is no meddlesomeness or undue haste in the conduct of the third state, the helpful power of this remedy will be as strikingly manifest as in the preceding stages. I have already given prominence to its efficiency as a prophylactic against the habitual hemorrhages of labor, and which chiefly assail this stage, and the incipency of the lying-in immediately following. It can hardly be questioned, then, that a remedy, having such power as a prophylactic, would be without great efficiency in its immediate use to meet the exigency of hemorrhage in this stage, though not of the habitual type.

C. The lying-in state. The adaptations of this remedy to the abnormal conditions of the lying-in, so far as my observations have extended, are limited to the hemorrhages I have already mentioned, and to the so-called after-pains, when they are either neurotic, as is common, or hemorrhagic in character, which is more common. That the remedy is capable of so valuable a ministry is evidenced by the experience I have again and again verified, that where the remedy had been given as a prophylactic to habitual hemorrhagic labors, or where the occasions of its use have arisen during the labor process, no after-pains of any special prominence have ensued. By reason of the capability to induce normality of the uterine contractile forces, *cimicifuga* covers alike the morbid irritability of the uterine fibers, which chiefly constitute the neurotic form of after-pain, as well as the atony of these fibers, which constitutes the after-pain of a hemorrhagic character. I have no satisfactory experience with the remedy in lying-in condition occurring later than the reign of after-pain distresses.

AIR PRESSURE IN SIMS' POSITION.

BY

CHAS. B. GILBERT, M. D.,
Washington, D. C.

AT a recent meeting of the Southern Surgical and Gynecological Association, Dr. John A. Wyeth read a very interesting paper on J. Marion Sims and his work, in which he made the same claim as that made by Dr. Sims, that the pressure of the air, when let into the vagina in Sims' position, causes the distention of the vagina and the replacement of the uterus.

I have waited many years for some specialists to point out

the error in this explanation; the fact that no one has done so, and that Dr. Wyeth, as well as all other authors, has reiterated the claim, is my apology for doing so.

It is a well-known truth in physics that *the pressure of the atmosphere is the same in all directions*; therefore, the pressure on the outside of the body will be the same as that within the vagina when opened. When the woman is placed in Sims' position, the abdominal walls fall away from the spine as far as the vacuum of the pelvis will allow; as soon as air is admitted, and the vacuum thus obliterated, the walls fall still farther, dragging the uterus with them; if any proof should be demanded, it may be found in the fact that the air rushes in with the sound of suction instead of as if forced in—gravity always acts in the same way under all circumstances. If anyone doubts, let him place the woman in the knee-chest position, thus exaggerating Sims' position, and he will get such a suction sound as will convince him; or let him bind the abdomen so that the muscles will be as rigid as the back, as near as may be, and he will get little change in the pelvis; there is no air sound when the woman lies upon the back.

All operations of nature are simple, when understood, and this one is no exception; the theory of distention by air pressure is not necessary to explain the phenomenon.

Dr. Sims' labors will be his best monument, but let us have the exact truth when we explain them.

Postscript.—Since writing the above, I have read in the *Medical News* of November, 1895, an article by Howard A. Kelly, M. D., Professor of Gynecology in Johns Hopkins University, on the "Diagnosis of Renal Calculi in Women," in which he says: "I placed the woman in the knee-chest position, passed a small speculum into the bladder and distended it atmospherically, so that all the bladder wall could be well seen." I wrote to Dr. Kelly asking him whether he agreed with Sims, or whether he claimed that the position operated to dilate the bladder and vagina when air was

let in. He replied: "I think the dilatation with air is due to the suction created by the gravitation of the viscera toward the opposite ends of the abdomen, or, if you will, by making the pressure within the vaginal walls less than the surrounding air pressure." The last part of this quotation does not express the true condition, it seems to me, but on the whole Dr. Kelly comes nearer to the true explanation than any writer whom I have read.

SUGGESTIONS CONCERNING " A CASE OF DYSTOCIA."

BY

B. H. OGDEN, M. D.

Professor of Obstetrics, Homeopathic Department, State University of
Minnesota.

THE keynote of greater success in modern obstetric surgery is "*election*." The physician does not wait until the exigencies of a case *force* upon him certain procedure, but after a most careful diagnosis, secured by a thorough study of the patient's history and, *most important*, an accurate pelvimetry, made with the assistance of anæsthesia, if necessary, he determines not only *what* operation is best adapted to a given condition, but *when* it is best to perform such operation. Given a case in which it has been predetermined that a Cæsarean section will be required, the obstetrician does not, as formerly, wait until labor has begun, but when the woman is near full term, has been thoroughly prepared, chooses his surroundings and the best time of day, and operates with much better results, not only because of improved technique, but very largely because he has deliberately chosen better surroundings and a better time for its performance. Important as is this principle of election in relation to the major obstetric operations, it is

of even more benefit in relation to the lesser operations. Take, for example, a slightly contracted pelvis. To allow gestation to complete its course, subjects the mother to far *greater* risk, to say nothing of the almost certain death of the child, but the induction of labor at an earlier date is likely to save both.

Let me apply this principle of "*election*," including of course a careful pelvimetry, to the "Case of Dystocia" reported in No. 2, Vol. XVIII, of the HOMEOPATHIC JOURNAL OF OBSTETRICS.

The history of the first confinement certainly pointed to some irregularity of the pelvis—probably of the variety most common in this country, viz., a *flattened* pelvis, and consequent diminished conjugate diameter. Certainly such a history would have made it of *prime* importance, in a subsequent pregnancy, to determine accurately the pelvic diameters, in order that the proper *time* and *nature* of interference should be *chosen*.

Having determined the diameters of the pelvis, further treatment of the case would depend upon *what* these measurements were. It would seem to me that the induction of premature labor, probably at 7½ months (the exact time being selected in accordance with well-established rules governing the times of inducing premature labor for certain pelvic measurements), was strongly indicated. Such an elected operation would have made labor in this case free from danger to the mother, and have given a reasonable probability of securing a living child.

In reply to the questions suggested by the author of the article, I would say:

First. An abortion was not indicated, unless the conjugate diameter of the pelvis was less than three inches. The term abortion here refers to the emptying of the uterus before the fetus becomes viable.

Second. The dark discharge was probably due to meconium in the amniotic fluid, but did not indicate the presentation. I have seen it in cephalic presentations,

NEPHRITIS IN CHILDREN.

BY

C. E. COLWELL, M. D.

REFERRING you to the various text-books for an exhaustive study of this disease and its treatment, I shall confine myself very closely to the recording of the results of my partner's, Dr. F. L. Bartlett's, thirty and my own ten years' experience.

Nephritis of children presents nothing distinguishing it from the same forms of the disease in adults. The only points of difference are that in children it is usually a sequel to some other disease; that it usually assumes the desquamative form, and usually ends in recovery.

That form of nephritis affecting principally the epithelial lining of the tubules and Malpighian capsules, called desquamative, or parenchymatous nephritis, is the form that our cases have assumed. They have been acute or sub-acute mostly, and but few chronic.

In my own cases, and in those of others for which I have made urinalyses, the cause has invariably been the exanthema or diphtheria, or complicated influenza, or infantile capillary pneumonia, or enteritis, either primarily or secondary to an endocarditis complicating or following one of the before-mentioned affections, except in one case. This was a case of idiopathic endocarditis, whose cause I

could not trace, which was followed by a diffuse desquamative nephritis. Starr and some other writers state that, strange as it may seem, it is never caused by exposure and "catching cold." My partner, however, recalls three cases due to colds contracted by boys while in swimming.

Nephritis follows scarlet fever more frequently than any other of the exanthemata, and is so mild in many instances as to hardly attract attention. As a rule it is severest after the severe cases of scarlet fever, and those mild ones with an incomplete rash. Rarely it follows the reverse ratio, a severe nephritis following a mild attack of fever. Next in casual frequency comes diphtheria, and especially those cases accompanied or followed by endocarditis.

Very few of our cases were ushered in with a chill or chills; these symptoms, if present, were overlooked. The febrile stage was usually very light and of rather short duration; a few carried a high temperature for a few days. The approach was often insidious, the child having apparently fully recovered from the primary disease, being about at play, the mothers having relaxed their watchfulness, thinking that the doctor was fussy and over-solicitous in his direction to watch the little one carefully, as to diet and exposure, for at least a month after the return to apparent health. The first symptoms noticed were usually the languor and listlessness of the little one, a little puffing of the face, most noticeable about the eyes, mornings; an increasing anæmia, peculiar in its yellow-white waxy hue. But seldom did they complain of pain anywhere. When they did it was usually in the back and head. Gastric and bilious symptoms accompanied some cases. Diarrhea, as well as sweat, I have learned to look upon as compensatory to the faulty acting kidneys.

The urine was more or less scanty and high-colored, often reddish brown, from the presence of blood; the relative quantity of day and night more or less the reverse of normal.

To heat or nitric acid, or heat and nitric acid, the urine showed more or less albumen. In bad cases I have seen it

appear at first nearly solid, settling on standing to one-half to two-thirds of the total bulk.

The microscope more certainly and earlier than anything else tells the exact story, whether you have a nephritis or not to deal with. It shows tube casts, hyaline, fine and coarse granular, epithelial cells and casts; in some cases blood casts and free blood cells; all in greater or less profusion.

Many cases reached their height when the dropsy was but a puffing of the face, hands, and feet, and returned to the normal health with but little treatment. In others the dropsy became extreme, the swelling extending from feet and legs to the abdomen, causing much distention and pressure on heart and lungs, and consequent dyspnoea. In these cases I have seen for several days the urine amount to but two or three ounces, the skin and lungs doing such work of compensation that the breath smelled slightly urinous, and the skin extremely so, the perspiration staining the clothing yellow, the skin being so poisoned by its excessive and unusual work that extreme desquamation took place after its relief, upon the kidneys resuming their own work. A diarrhea in some cases aided the work of compensation.

I have been surprised at the length of time that the urine would be very scanty, almost suppressed, and still dangerous symptoms and a fatal termination not supervene.

Coma in a few cases indicated the extreme danger. Convulsions, with nephritis, in children I have never seen.

We have witnessed a fatal termination in but one case, a lad of about four years, who had apparently recovered from scarlet fever, whose mother we had warned to be very watchful, to whom we were called again in about three weeks to find endocarditis and nephritis well developed. He had played out-doors during damp weather. Our remedies gave but passing or questionable relief. The heart and kidney lesions marshaled their symptoms equally to a distressingly fatal termination, which was prefaced by a sleep, partly exhaustion, and partly coma.

The tendency of nephritis in children is to complete recovery; but few become chronic; but few die. Therefore in most cases a favorable prophecy can be given. Do not forget that chronic nephritis is a constant menace of death. Mild cases mismanaged easily and quickly become dangerous, hence be very watchful and careful of all your cases, and a little cautious in your prognosis. Those cases complicated or accompanied by an endocarditis are serious and dangerous, and the prognosis should be, if not unfavorable, at least very guarded.

In summing up we have found the cause to have been some preceding disease, as the exanthema, diphtheria, etc., but have observed a few cases caused by exposure while bathing and catching cold; insidious, rather than abrupt invasion; lack of pain, but little fever in most cases; complete recovery generally; a few become chronic; prognosis, as a rule, favorable; bad or guarded if accompanied by heart disease.

Treatment.—Rest in bed or chair. Persistent warmth and frequent bathing to cause free action of the skin. Diet: Milk principally, or milk and cereal foods; some eggs, rare beefsteak, or roast beef, or rare chopped beef fried in balls; in fact, a very plain, light diet. Plenty of the softest, purest water obtainable; if water is hard, boil to throw down some of the lime, and allow to cool.

The remedies we have pinned our faith to, and have seen cure, or help to a cure, are not many. They are acon., apis. mel., ars., canth., eriger. can., merc., and tereb. If there be fever, acon. 1x or 2x dil.; drop dose in teaspoonful of water every half hour or hour.

If dysuria, and other bladder symptoms be present, canth. 2x dil.; drop doses half hour to hour.

If fever has subsided, or be absent, and bladder symptoms are wanting, or have been controlled, the puffy face and feet in the morning, the more or less pronounced pallor of skin which, if the disease lasts long enough, will

be a peculiar waxy hue, in fact the most frequent picture that tells us we have nephritis to deal with, suggests apis mel., 3x trit., a powder every two or three hours.

If the urine is quite bloody and acrid, and scanty, terebinth 3x dil.; one-third drop doses every half hour or hour, often between the apis powders, during the excess of the symptoms, and three times daily after improvement has begun.

Thirst for cold water, small quantity and often, nausea or vomiting, restlessness, possibly loose stools, ars. alb., 3x trit., every two hours.

If liver complications be present, merc. cor. or sol. 3x trits., or chelidon. 2x.

Unsteady, fussy, or feeble heart, digit. tinct., five to fifteen drops in glass half full of water, teaspoonful every half hour or hour.

For hemorrhage from the kidneys, acon. 1x, or 2x, terebinth 3x, and ham. tinct. or 1x, were formerly our standbys. Recently I had been having such favorable results from erigeron can. 2x dil., or the oil in the 1x, in hemorrhages in general, that I was led to prescribe the erigeron can. 2x dil. every half hour, and later every hour, in a case of diffuse desquamative nephritis accompanying endocarditis, in which the dropsy was pronounced, urine scanty and very bloody, which had been improved some by apis and terebinth. Improvement having ceased, I gave the erigeron in connection with the apis, with the result not only of controlling the hemorrhage, but also of a quite rapid clearing up of all the other symptoms, making the ensemble a complete cure of the nephritis.

The relative value of the remedies, as gauged by the relative frequency in which they have been used, and have given good results, is about as follows, in the order named: apis. mel., terebinth, acon., canth., ars., dig., and erigeron, with good prospects of erigeron being advanced toward the head of the list after further use.

ENTERORRHÉE ROSÉE HÉMATIQUE.—ITS
DIAGNOSTIC AND PROGNOSTIC VALUE.*

TRANSLATED BY

B. F. UNDERWOOD, M. D.

ENTERORRHÉE ROSÉE HÉMATIQUE, to distinguish it from enterorrhagia, which implies an abundant hemorrhage, and from dysentery, by which term is meant a frequent and painful diarrhea, with discharge of blood, is a light flux, of a purplish color; rather an oozing than a flow from the intestines through the rectum, which stains the diaper of an infant like a red water.

The classic authors describe the losses of blood which follow upon certain occlusions which terminate by an escharotic breaking down of the intestines, but do not consider the aggregation of symptoms of much value in the diagnosis, so difficult, of an intestinal occlusion at its commencement, in early infancy.

This aggregate of symptoms, upon which the classic authors are for the most part mute, is found in early infancy. In spite of its rarity, I have twice observed and studied it, at some months' interval, in two young subjects, one of whom was still at the breast, the other about to be weaned. These two cases furnish the occasion to speak of this phenomena from the double point of view of prognosis and diagnosis, and also therapeutically.

Enterorrhée rosée hématique, a precious clinical sign, often passes unnoticed. For, it is rarely that the mother or nurse remarks by chance, the fact of finding many times a day the swaddling cloth of the child unspotted with golden yellow matter, sign of health, but simply soaked in urine, the circumference of the humidity appearing red, sometimes on one spot only, according as the color is more or

* From the French of Dr. Le Grix.

less moistened or diluted. If, as rarely happens, since there is usually constipation, some fæces are found on the diaper, they are circumscribed by a light purple tint. The attention will be always aroused when the napkin is not wet and only the rose colored spot, two or three inches in diameter, is seen, the more plainly because less diluted by colorless liquid.

Careful parents, attentive observers, alarmed by this peculiar discoloration, will call the physician; who at first considers the spot as the result of a discoloration in the linen, but with more attention quickly recognizes the presence of the coloring matter of the blood.

Generally, the apparently insignificant spot will be attributed, by the physician, to an excoriation of the anus, for which he will seek in vain, and retires, attaching little or no importance to the symptom; for, aside from this, the child does not appear to be sick. It may be a little disturbed, complain more, have been constipated for two days or more; it cries more than is usual, takes the breast badly or refuses to drink, but it has no fever. Nevertheless, the belly is a little distended, slightly painful on pressure, and the infant sometimes vomits from time to time, particularly after taking anything to drink or after nursing; the diapers are rarely moistened; the legs are drawn up upon the abdomen and held there as when a child suffers from colic. In a word, the malaise will be attributed to teething, constipation, etc.

Twenty-four, thirty-six, or forty-eight hours after the appearance of these slightly characteristic signs, three days or more, the infant dies, without presenting any salient symptoms, without having appeared to be in danger. At most, it has appeared to suffer only by some persistent cries, which are attributed to the distention. The color becomes of a citron yellow, with rings about the eyes, which are crossed. The physician in his own mind will be as greatly surprised at that death as the family themselves.

These are the symptoms; the course, the duration and termination of this mortal affection which announces its presence most frequently by some rose-colored spots upon the diaper one or two days before any other symptom.

What, therefore, is the diagnosis of this insidious malady? With what disease may it be confounded? What therapeutic indication should be advised, at once unraveling and explaining this evil omen; this light loss of the serum of the blood?

If the physician attaches a serious importance to this red oozing, and is anxious to trace it to its source, different problems will present themselves for solution, after the microscope has confirmed the diagnosis by revealing the presence of the coloring matter of the blood in the discharge. It may be thought to come from an excoriation or fissure of the anus, from a prick of a pin, from ulcerative erythema, pemphigoid, bulla, from prolapse of the rectum, inflammation of the appendix, dysentery, intestinal occlusion from accumulation of fæces, invagination, strangulation, volvulus, etc. Although, very exceptionally, infantile hemorrhage exists, we know that before the age of ten years it is in the form of epistaxis. It is true that this is not a hemorrhage, but a simple oozing out, recurring several times a day for several days.

Simple inspection of the parts rejects the possibility of this oozing arising from excoriation, erythema, or pin prick; and in ulceration the oozing would contain pus globules, and would not have this purplish color, not sanguineous. Prolapsus of the rectum would be sufficient explanation of the colored spots, and its coincidence with obstinate constipation would render difficult the solution. Inflammation of the appendix and dysentery do not exist in infants before the age of six months [Blache]; toward the age of three years these diseases appear, and if they give rise to the inflammatory phenomena it is not without fever. Dysentery is very rare in children before the age of nine

years [Billard], and the frequency of the stools removes all doubt. Occlusions by worms is exceptional, and a vermifuge will within twenty-four hours remove the doubt; obstruction from simple accumulation of fæces does not exist in the infant, and a purgative resolves that question; strangulated hernia is usually apparent, is painful, sometimes febrile, and does not occasion sanguineous oozing. With invagination, however, it is different. It is with the youngest infants that the concordance of obstinate constipation and of sanguineous oozing is pathognomonic of invagination, of intestinal strangulation, most rarely of the ileus, of volvulus, of an epiploic bridge, exceptionally of strangulated hernia. By elimination, therefore, we arrive at a diagnosis of intestinal strangulation from invagination or other causes. This being suspected, it is well to explore lightly the abdomen. Then, we often find under the fingers a tumor, more less voluminous, seated usually on the median line in the hypogastric or vesical region, sometimes slightly to the right. This might be taken for the distended bladder, without the mobility, the sensibility, and negative sounding. This small tumor is not always perceptible, but the belly is greatly distended and hard, the constipation obstinate and does not yield to castor oil; croton oil [a drop]; to lavements, etc.

If the importance of this sanguineous oozing is ignored, and the diagnosis established by elimination, its certainty should be established beyond question. Invagination of the intestines is susceptible of medical treatment before surgical intervention is resorted to. Medical treatment appears to be more and more abandoned for the knife. Ineffective medical treatment should give place to an early operation [Congress at Washington, 1887]; these cases are fatal from the delay in employing surgical means. [Society of Surgeons of Paris]. Medical methods should always precede the intervention of the surgeon [Curshman of Leipzig, Congress of Weisbaden, 1889]. Nevertheless, it

is necessary not to forget electricity [galvanic current], which has given the best results [seventy per cent.] to Boudet of Paris [1882], with electric lavements, according to Leroy of Étiolles and Duchenne of Boulonge, to Lerat, Fleuriot, Doyen, Bucquoy, Monod, etc. If it is not convenient to employ electric lavement, descendant faradization with inversion may be used. Hyoscyamus and brucine are also indicated, in the beginning, with these little beings, until the physiological or therapeutic effects are obtained, particularly in invagination, strangulation, and stricture. But if the adherence remains at the end of several hours, there is no longer any hope of dividing it by the action of the medicine.

In the cases we are considering, laparotomy will be always the last resort. For the statistics are bad [sixty per cent., Payot; fifty-eight per cent., Schramm] with adults. What will it be with the young subject whose tissues support the knife so badly? In spite of there being only one chance of success in a thousand, that one chance should be taken, for an occlusion, if not overcome, inevitably causes death in the adult, and the spontaneous cure by the elimination of the invaginated part is not to be considered. In the infant the one chance which surgery offers should be taken.

Case I. Sunday, the 2d of June, 1889, I was called by an honorable confrère, Dr. V., to see his young baby, about six months old, a healthy child of good constitution, which had been constipated for about twenty-four hours, refusing the breast, and continually crying, contrary to its usual habits. The mother had noticed a humid spot on the diaper. At my examination, I found nothing abnormal about the anus, but the abdomen was greatly distended. I ordered a small lavement of honey of mercury, fifty grammes, and a decoction of marshmallow root [fifty grammes], and in addition a coffeespoonful of castor oil. The same evening, at seven o'clock, there had been no stool, and the injection had been returned unchanged. The infant was in the

same state, and a new spot was shown on the napkin. I expressed my fears of an invagination, the more so that the urine was scanty, the bladder empty, and yet the abdomen was swollen, and a small tumor, the size of a hen's egg, could be felt in the right flank, the long diameter toward the median line. I ordered another spoonful of castor oil, with a drop of croton oil, and examined the sanguineous oozing, to which I attached great importance. No modification at my visit that night, in spite of two granules of hyoscyamine and brucine. It was decided to call in consultation Dr. Oliver, hospital physician, who believed, without being positive, that it was an invagination. The tumor now reached to the line of the bladder. He advised gaseous injection, the distention of the intestines by water under pressure, the head lowered, faradization baths, etc. The next day if there should be no change laparotomy should be performed. On the evening of the 5th there being no improvement, Dr. Quinn performed laparotomy, and found an invagination of jejunum of about $1\frac{1}{2}$ in. The infant died four hours after the operation.

Case II. The infant, D., weaned, about a year old, was suddenly taken, while in good health, with an access of crying. From that time he became depressed, refused all nourishment, and gave himself up to spasms of crying. The mother called me in about thirty-six hours after the change in the child. It was Monday, September 30, 1888. He had not had any stools since he was first taken, his diapers were only slightly moistened, and there was some nausea and vomiting. At my examination of the little patient he did not appear to be ill, only that he was slightly pale, without fever. His abdomen was swollen, and painful on examination, but palpation disclosed nothing abnormal. But upon examining the diaper I remarked the characteristic colored spot, that no local cause, pricks, erosions, pemphigus, or eruption could explain. I did not conceal from the mother the grave state of the child, and the possible neces-

sity for an operation, for which it should be sent to the hospital. I prescribed castor oil, five grammes, one drop of croton oil, mercurial and gaseous injections, without result; also six granules of brucine and hyoscyamine.

The next day, October 1, I used the faradic current, without success. Without delay I advised the mother to take the poor child to the hospital at once, with a note explaining the diagnosis and asking for an immediate operation as the only hope of saving the child's life. But the child was not operated upon, and died the next afternoon.

Conclusions: Enterorrhée rosée hématique is observed in very young children, the most often in those in swaddling clothes. Enterorrhée rosée hématique is characterized by an oozing, not abundant, of sanguineous serum, from the rectum, spotting with a light purplish tint the diaper of the child. The spots, subjected to a microscopical examination, show the presence of the serum and the coloring matter of the blood, and proves the transudation of the coloring matter through the invaginated intestine. In very young infants, enterorrhée rosée hématique, coinciding with obstinate constipation, sometimes with a small tumor in the hypogastrium, and distention of the abdomen, is characteristic of invagination or of intestinal strangulation. Its appearance is of very grave import. Surgical intervention, although often useless, is the last resort when medicine and electricity have failed.

IMPERFORATE HYMEN.

BY

MILTON J. BLEIM, M. D.,

OF all forms of atresia of the female genital canal, imperforate hymen is the simplest. Simple as it is, its occurrence is rare. I suppose many practitioners have never

seen a case. Is it not wonderful that nature should so seldom overlook this little provision of a slit in the hymen for future needs? This, of course, is not nearly so serious a condition as is the next degree of atresia, where either a portion or the whole of the vagina is closed as well, for this is much more difficult to relieve. In this connection I may be permitted to describe briefly a freak of nature, born in our own city of Galveston, and which was recently on exhibition in San Antonio. This person is twenty-three years of age and in perfect physical health. She (for the feminine predominates) is about 5 ft. 6 in. tall, and is formed in general outline like a woman; perfectly symmetrical female extremities, shape of shoulders, hips, and waist that of a woman. The voice is distinctly feminine; she sings correctly and sweetly in a treble tone. The face is full and oval—the breasts are full and yet not so much like mammary glands as like the fullness of a fleshy man—There is not a hair on the face or body, neither in the axillæ nor over the pubes. Strangest of all is the absolute absence of any external genitalia, with one exception. The skin from the anus (which is normal) to the pubis is perfectly smooth and void of any indentation or scar. There is some deposit of adipose over the pubis; this deposit is on the right side somewhat fuller than on the left and in it can be felt a small gland, about the size of a small almond; whether ovary or testis is speculative. It is not sensitive and does not give rise to the peculiar sickening feeling on pressure. Just underneath the pubic bone, under the arch, is a small fold of pigmented skin, resembling in appearance the elongated prepuce of the penis. In this is an orifice through which the bladder is evacuated. The finger can be pressed backward into this fold to the neck of the bladder, of which there is perfect control. She claims to be totally void of any sexual sense or shame. It was not convenient for me to make digital examination per rectum, but those who have done so assert

that they can find no trace of uterus or ovaries. I have never seen a reference to this person, though it probably has been described and is undoubtedly one of the most remarkable freaks in existence. She was brought up as a girl, but now dresses in male attire.

Some months since, I was called upon by a gentleman to prescribe for his daughter. He said he feared she had taken cold and was threatened with peritonitis. She was suffering considerable pain in her abdomen. I naturally questioned him about her menses, when the history was elicited of a girl of ordinary size, aged $19\frac{1}{2}$ years, who had never menstruated. She had been taken to a physician six months before who had prescribed for her several times without result. She never suffered any pain nor gave any indication whatsoever of approaching menstruation. So it was decided to leave her to the kindly offices of nature. As there were no ill results nor any indications for it no physical examination had ever been made. She had never suffered the slightest pain until some weeks previously, when she had an attack similar to this but not so severe. I put up some medicine and dismissed him. About midnight he called again, said his daughter was having more severe pain and requested me to go with him to see her. After a few preliminary questions I placed my hand on the abdomen to examine for tenderness and distention. I instantly felt under my touch a globular tumor, extending to the umbilicus and almost completely filling the lower half of the abdomen. In the very apex of the swelling I could outline a small, round body, considerably harder than the rest of the mass. There was no special tenderness nor was there any fever. Recalling the history of the case I at once suspected that we had here a case of obstruction to the menstrual flow. I was further fortified in this opinion by discerning before me a fully developed woman. There was every mark of maturity in the breasts and external genitals. Inspection and palpation of the

hymen revealed the absence of the usual orifice. Digital probing of the rectum found it obstructed by a tense globular tumor. The diagnosis was plain—the pains were caused by the recurrence of a monthly flow, which was now crowding a distended sac already full to bursting.

Consent to give operative relief was gladly given and carried into effect the next day—strict asepsis was observed. The hymen was very thick and unyielding and was first pierced by a trocar and canula. The thick, tarry fluid could not flow easily through the canula; it was therefore withdrawn, a grooved director inserted and stellate incisions made. Care was taken to evacuate the contents very slowly, about an hour was consumed in the process and upward of two quarts removed. It was found that the sac was formed by the dilated vagina, and that the hard body which I had felt under the navel was the normal uterus. Where the uterus and tubes are also dilated the condition is still more serious. After the contents were all evacuated the hymen was thoroughly stretched and the cavity douched with a carbolized solution. It was then gently packed with iodoform gauze. This dressing was repeated several days in succession and then every second day. In ten days the case was discharged, having made an uneventful recovery. She has since menstruated naturally each twenty-eight days, within six weeks the vagina had contracted to its normal size and the uterus had descended to its proper position.

I could not, upon the closest questioning, discover that this young woman had ever had the slightest cognition of her condition or of the existence of that cyst. It seems almost incredible, but it shows how gradually and kindly nature can accommodate herself to pathological conditions. There are two points which I would made in closing this paper:

First. The importance of making a local examination of girls who go beyond the usual age without menSTRU-

ating. Had the other physician examined her she could, no doubt, have been relieved six months sooner. It is doubtful whether I would have made the examination under ordinary circumstances had I not been directed to it by the abdominal pains. The girl was in such natural health that it was taken for granted that she was simply tardy; and yet nature had been faithfully performing her function for years, until it must seem that ere long rupture of the vagina would have been inevitable.

Second. I would call attention to the safety with which, under scrupulous aseptic procedure, this condition can be relieved—as contrasted with the fatal results from septicæmia in pre-aseptic days. Simple as is the pathology and trifling the operation, yet it is a fact that under the old method septic results were sadly common and the fatal end was only precipitated by the surgeon's kindly efforts to save.

THE IMPORTANCE OF IMMEDIATE REPAIR OF THE RUPTURED PERINEUM.

BY

EVA G. CONDON, M. D.

NINETY per cent. of the married women who come to me for treatment have in a greater or less degree a ruptured perineum, dating, of course, from childbirth. And the question continually arises in my mind, Why are these women neglected in this manner; why do not those officiating repair the damage immediately? I never allow a wound of that kind to get cold before I repair it. 'Tis so much easier done then, because the wound is fresh; besides, it can just as well be healing while the woman is lying-in the necessary two weeks, and then when she gets up, she is

strong and well, and will bless the wise doctor all her life, although she did demur a little at the time; when, if she has been neglected in this particular, she drags herself around for weeks, months, and years! until she can bear it no longer, and seeks relief at the hands of a physician, and then only does she ascertain the cause of all her troubles. Now, we all know the awful condition we find these women in. A prolapsed, relaxed, flabby condition of the walls of the vagina. A subinvolted and prolapsed womb dragging on the pelvic ligaments, causing that well-known backache and that awful pain in the top of the head and in the ovarian region, associated with gastric and portal derangements. I always tell these women when they apply to me for relief, that I can relieve them temporarily by treating them and building up the system, but cannot guarantee them permanent relief unless they have this rent repaired. Now, this means a matter of two or three weeks' loss of time to these people, which, in the majority of cases, they can ill afford to spare from their families and home duties, besides the expense incurred, which is an important item to the great majority. The consequence is, we seldom get them to submit to the operation, rather preferring to be patched up for the time being, until some more convenient time, which never comes, and the poor woman ekes out a miserable existence, where, if she had been properly handled at the time of her accouchement, she would have been a strong, healthy woman, a comfort to herself and family. I often come across women who date their troubles to inefficient midwives. Here 'tis not so much to be wondered at, for we all know what they are capable of. But when a licensed physician is guilty of such gross neglect, I think it inexcusable.

I have heard physicians say that a patient is too exhausted after a hard labor to endure the extra tax occasioned by the immediate repair. I venture to say that I have had some of the most exhausting cases in existence,

and have in all cases repaired the rupture with perfectly satisfactory results before the child was an hour old.

I would like to offer a hint in this connection, regarding the method of managing these cases after the repair is made. We all live to learn, we all learn by experience, and are never too old to learn. My habit heretofore has been to have the woman lie on her back, with the knees secured by a towel pinned around them.

I found this impracticable, as the lochia seeped through the wound and interfered with the perfect adhesion of the parts. Now, I have her lie on the side so that the parts naturally fall closer together, and have more perfect union.

In repairing old cases of this kind, this precaution is not necessary, as there is no internal discharge to cope with.

REPAIR OF OLD RUPTURE OF THE PERINEUM AT SUBSEQUENT CONFINEMENT.*

BY

H. D. BISHOP, M. D.

I AM quite aware that in the subject of this paper I have stated a course of procedure that is liable to call down upon it the condemnation of some, from the fact that the method is unusual. However, I present it with confidence, because as yet the objections to the method by others are only based upon ideas of what might happen.

The title of my paper explains itself—the repair of an old injury to the pelvic floor at a subsequent confinement.

The method has for its most important element of commendation the fact that the woman is saved the extra two or three weeks in bed, which a perineorrhaphy at any other time requires. At first thought this would not seem of

* Read at the Twenty-third Annual Meeting of the Homeopathic Medical Society of Eastern Ohio, April 15, 1896.

very much importance, yet the time spent in recovery from an operation, and the expense as well, is a feature which deters many a woman from having a perineorrhaphy when the conditions really require it. In fact, the latter consideration was that which induced me first to practice this method. My patient did not feel able to have an operation, and had delayed it for several years. In the meantime she became pregnant, and it was decided that at her confinement the perineorrhaphy should be performed.

The operation does not change at all the ordinary course of the puerperium, and if the proper technique is followed, the method does not add to the risk of the puerperal state.

The kind of operation chosen is immaterial. Yet I believe that the modified Tait operation, as performed by Dr. Wood, offers the least chance for the the absorption of decomposed discharges, and I therefore prefer it. However, the presence of decomposed discharges shows that the antiseptic technique is at fault. If every detail is carried out the discharges will not be dangerous.

The success of the operation and the safety of the patient depends entirely, I might say, upon the antiseptic technique followed before, during, and after labor. This, even in regular obstetric manipulations, outside of obstetric surgery, is of such importance, and yet so neglected by many practitioners, that I venture to give it in detail.

It is taken for granted that the physician, nurse, and assistants will conform to the proper technique in preparing themselves for the subsequent manipulations of the patient. This should include thorough cleansing of the hands and clothing, instruments, and dressings.

The antiseptic technique of the patient herself should be as follows :

1. As soon as labor begins, the bowels should be thoroughly flushed in the knee chest position. The fact that the patient has had a natural movement is not sufficient evidence that the bowel is empty of fecal matter.

2. The external parts and vagina are thoroughly scrubbed with green soap, and washed with HgC 1-2000. This is followed by a wash with two per cent. creolin solution, and next with sterilized water. After this a vulvar pad of absorbent gauze, saturated with the creolin solution, is placed over the parts and held in position with a sterilized T bandage. Sterilized leggings are then placed on the patient. When examinations are made the pad is not removed, but simply pushed aside.

In hospital practice, and in private practice as well, I believe it better to use a table for the patient to lie upon rather than use the bed, for one can then carry the antiseptic technique to the operating table itself.

In the future I also intend to further guard against infection from the rectum by placing over the anus a square of rubber tissue, fastening it to the skin with collodion.

3. Labor completed, the patient now fully under the anæsthetic, the parts are shaved and again washed with HgC creolin solution and sterilized water, and the operation for the repair of the perineum done. If buried sutures are used, I use catgut, but the sutures which come on the surface should be either silkworm gut or silver. As it has been shown by bacteriological tests that catgut perfectly sterilized has a conductive action in carrying skin infection into the deeper tissues, if catgut is used it should be a subcuticular suture. Sterilized salt solution is used for irrigation.

4. The operation completed, the vagina irrigated with the creolin solution and sterilized water, a vulvar pad is saturated with the creolin solution and placed over the vulva. Over this is placed a piece of oiled muslin, and over this a layer of sterilized absorbent cotton, all being held in place by a sterilized T bandage. This dressing is changed every four hours for the first twenty-four hours, and every six hours thereafter.

At each dressing the patient is placed upon a bed or douche pan, the dressings removed with sterilized dressing

forceps, and the parts douched with sterilized water. If urination has taken place, HgC should be used first, and then the sterilized water. This douching is best done by the nurse by pouring the solution from a pitcher or from a flask.

One cannot insist too strongly upon the minutest detail of this antiseptic technique. The parts dressed should never be touched by the nurse, unless her hands have been previously sterilized.

With this technique there can be no danger to the patient from without, and it is now an accepted fact that there can be no danger from the woman herself.

I have performed perineorrhaphy, and in one case, anterior kolporrhaphy, five times, since I adopted this method. At first I operated with considerable hesitancy, but finding that I had no complications I came to look upon it as perfectly rational obstetric surgery.

If the proper antiseptic technique is followed one can operate with perfect safety upon the parturient woman, and from my own experience I feel warranted in saying that whatever injury there may be to the pelvic floor, be it old or recent, it should be repaired by the obstetrician.

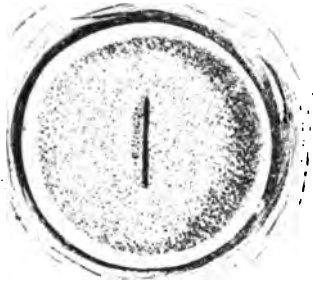
SOME VITAL CAUSES FOR ANTEVERSION AND ANTEFLEXION.

BY

J. C. NOTTINGHAM, M. D.

IN "Anteversion and Anteflexion," an article from Ball's Headly's "Evolution of the Diseases of Women," there is this reference to a very probable factor in the ætiology of all uterine and ovarian affections, to wit: "The strong structure implies healthy development and sexual activity, so

that, should marriage and pregnancy not presently occur, the progressive inflammatory pathology of anteflexion of the second virginal degree [Here I must confess my ignorance of virginal degrees.—AUTHOR.], if not already present, is liable to occur.”*



Virginal well-developed os with rubbed-raspberry granular face, and areolar hyperplasia compressing the lips.



Diagram of position of uterus.

FIG. 1.

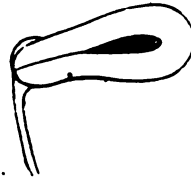
Anteversion is only found in well-developed uteri, where there is no angle of feebleness at the junction of the cervix and body, so that the cervix does not bend and become anteflexed; the vaginal cervix and the os may be normal, and the position the result of excessive abdominal pressure, commonly tight-lacing, which depresses the fundus. The opening may be congenitally small, and the vaginal cervix conical from irritative difficulty of drainage inducing contraction of the cervical circular muscular fibers; or congenitally large, or in the parous lacerated, with everted

* At my suggestion the publisher of the JOURNAL OF OBSTETRICS will present in substance, with illustrations, the article referred to.

granular tissue and cervicitis, leading on to corporeal endometritis and undue weight of the body, which thus falls. In any case the whole uterus rotates on a transverse axis at the cervico-corporeal junction, and the cervix is tilted up and looks more backward; and the organ being well developed, there is no angle of flexion, and the cervix follows the line of the body; or the displacement upward



Normal relation of uterus to vagina, showing absence of friction of face.



Anteverted uterus, showing friction of face against the vaginal rugæ.



The face of the above uterus like a rubbed raspberry from friction against the rugæ of the posterior vaginal wall.

FIG. 2.

of the uterus may be caused by an attached tumor, or by one occupying a lower plane in the pelvis; or in great conjugate pelvic contraction with distention of the abdominal walls, the pelvic space is deficient, and the uterus lies over the symphysis pubis.

Progressive Evolutionary Disease.—When the cervix occupies its normal position, lying at an obtuse angle with the vagina, without abdominal pressure there is no friction, for movement of the body of the uterus only induces the face to move slightly almost in the axis of the canal of the

vagina, parting its sides. But when the cervix is at about right angles to the vagina, and particularly when the position is maintained by abdominal pressure, the face must at every movement be frictioned against the posterior wall of the vagina (fig. 2). Should there have been any degree of previous irritation of the face, it becomes yet more irritated, granular, and hyperplastic, and higher evolutionary effects are likely to ensue.

The persistence of these causes, combined with the passage downward of the fæces and their retention in the rectum, may gradually overcome the resistance of the cervix, the descent of which thus occurs, producing anteflexion; an angle, generally at the cervico-corporeal junction, being determined. The strong structure implies healthy development and sexual activity, so that, should marriage and pregnancy not presently occur, the progressive inflammatory pathology of anteflexion of the second virginal degree, if not already present, is liable to ensue. In the case of complication with a tumor the uterine evolution is secondary to that of the tumor.

Anteflexion.

The condition is of two main kinds. The first is where the cervix has about its normal position or is perpendicular, but the body is depressed and perhaps horizontal, and the substance of the uterus is usually of good development. In the second, the cervix looks forward and downward, while the body maintains the normal direction or is depressed, and the uterus is usually feebly developed. Modifications of these conditions also occur.

In the virginal condition the anteflexion is:

Evolutionary from anteversion produced by undue abdominal pressure:

Evolutionary in a uterus in a state of congenital defect.

Parous anteflexion is the product of one of two sources of origin, in which:

(a) The os is normal, with subinvolution and chronic endometritis; and

(b) The vaginal cervix is lacerated, generally as an evolution of the condition of virginal anteflexion.

Mode of Causation.—A healthy uterus, occupying its variable normal positions, being subject to adjacent pressures according to the quantity of the contents of the

bladder and rectum, is liable to the influences of undue abdominal pressure. If pressure, as stays or dress, compress the waist, as the intestines cannot be forced upward because of the diaphragm and the bony case of the ribs, they must descend. The direction of least resistance



Virginal orifice face and opening.



Horizontal body in uterus of good development.



The same with also perpendicular cervix.



The cervix is bent forward, the body is normal. Good development.

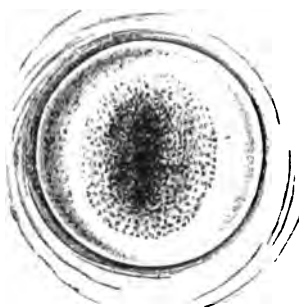


The cervix is bent forward, but the angle of flexion is at the middle of the cervix. Good development.

FIG. 3.

would be anteriorly through the more or less variable distensible abdominal wall; but the stays have strong steels which descend over the abdomen to the pubes, and produce an anterior support. A powerful force is thus directed into the pelvic cavity, which is resisted by its contents, and finally by the pelvic floor, which in the virgin is complete.

Thus the force acts immediately on the fundus, which it tends to depress. The uterus being here assumed to be of normal development, firm in its structure, and therefore also at the junction of the cervix and body, has no original tendency to flex, but rather rotates forward on a transverse axis at its cervico-corporeal junction, effecting anteversion. This, however, cannot usually be long maintained; for the intestines, being forced downward by the superior pressure on to the posteriorly uptilted cervix, depress it, when an angle of flexion is formed, in which the body is more or less horizontal, and rests on the bladder, and the cervix looks downward and backward, or is perpendicular.



Virginal opening of large development with cervical hyperplastic eversion with granular faces.



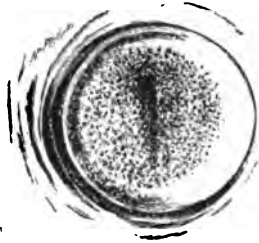
The congested body is horizontal.

FIG. 4.

Should this condition be accentuated, there is some descent of the uterus, which takes place in the axis of the pelvis by rotation backward on a transverse axis at the cervico-corporeal junction, so that the cervix may look a little downward and forward, and constipated rectal fæces may force the cervix farther forward.

Progressive Evolutionary Pathology.—The os being healthy and well developed, the canal patulous, and the

angle of flexion but of moderate degree, there is usually an unimportant degree of obstruction and no endometritis. Where the fundus is markedly anterior, the tubes are angled at their junction with the uterus, and thus it may be that tubal obstruction may be presently induced, which may lead to dysmenorrhea and tubal peritoneal effusion and peritonitis, ovarian thickening and adhesions. But the



Virginal normal opening with granular face from friction, in a girl æt. 17, with a good hymen and dysmenorrhea.



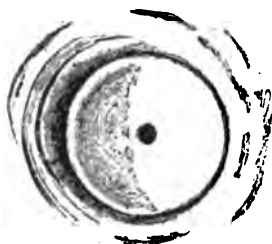
The cervix is pushed forward by feces retained in the lower rectum.

FIG. 5.

pressure, if from dress, is intermittent; and there are many hours, as of the night, and if there be dysmenorrhea, when it is absent. Also the uterus is well developed, so that it is apt to recover itself, and pregnancy may occur before evolutionary organic disease has been induced.

(a) With a large opening and congenital granular eversion and cervicitis the vaginal cervix may occupy the normal position or be perpendicular. The os is large, with everted raw-beef-looking tissue, exposing the corrugations

of the arbor vitæ ; and the epithelium may also have been removed from the adjacent edges of the vaginal cervix by friction against the vagina, or by the irritation of inflammatory secretions, and resemble a rubbed raspberry ; a plug of



Virginal conical cervix and pinhole opening in otherwise strongly-developed uterus.



Anteversion of the same uterus.



Horizontal body and perpendicular cervix from fecal pressure in the same condition.

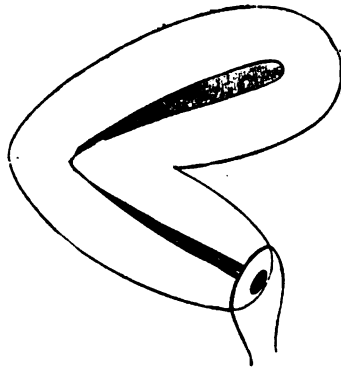
FIG. 6.

cohesive mucus protrudes from the opening ; its adjacent tissue is hyperplastic ; the external non-granular part of the vaginal cervix is congested ; the body is heavy, congested, and horizontal. The sexual activity is marked.

Mode of Causation.—In this development the exposure of the cervical tissue and friction against the vagina increase the irritability. On the occurrence of the catamenia, the

congested cervical membrane protrudes the more, becomes more hyperplastic, and tends to block the mouth, so that the secretions, increased in quantity, find greater difficulty in escaping; whereby the body tends to be distended, and the muscular fibers contract and overcome the obstruction; but irritation, congestion, endometritis, and depression of the body result, with an angle of flexion which increases the obstruction of the canal.

Progressive Evolutionary Disease.—From the friction of the everted, chronically inflamed, granular, hyperplastic cervical tissue against the vaginal rugæ, and the action of the acid vaginal secretion on the alkaline cervical glands,



Anteflexed uterus of feeble development, with small opening and almost no vaginal cervix. The vagina is attached at the edge of the small face, especially anteriorly.

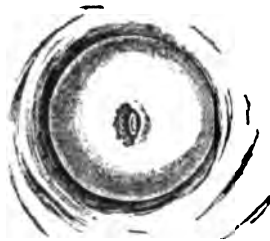
FIG. 7.

cervical obstruction ensues, which affects the corporeal endometrium. Corporeal endometritis results, with its determined and markedly evolutionary effects on the tubes and ovaries.

The body of the uterus being unduly heavy and lying on the bladder, micturition becomes frequent, and presently necessitous and painful; the bladder is congested and its muscles irritable and spasmic. There follows puffing at the entrance of the ureters, and the flow of urine through them may be hindered; the calices of the kidneys may become distended, and if there be a tendency to lithic or other cal-

culous deposit, it may collect in the kidneys, and suppuration round a stone finally result.

(b) The second class of virginal defective anteflexion is where the opening is small in a normal or conical vaginal cervix in an otherwise strongly-developed uterus; there is endometritis, and the body is depressed by excessive weight; and there is marked sexual activity. The cervix occupies the normal position, looking downward and backward, or later, by evolution downward; the body is hori-



Virginal feebly-developed uterus with conical cervix, small opening with granular edge of posterior lip, and anteflexion of body and cervix. The ovaries and tubes posterior; tender amenorrhœa, three years. Aged twenty-three.



Diagram of anteflexion of body and cervix of feebly-developed uterus.

FIG. 8 AND 9.

zontal; the face congested, and frequently angrily granular; the small opening is occupied by a morsel of inflamed and thickened, everted mucous membrane; the uterus is tender on pressure; the endometritis is of an active character, and leucorrhœa is persistent, though not large in quantity.

Mode of Causation.—From birth the deficiency in size of the opening has prevented the ready escape of the mucus.

At the commencement of the catamenia the primary congestion of the lining membrane still farther blocks the os, and on the occurrence of the flow the fluid collects in the cavity more quickly than it can escape; some distention results, and muscular contraction with pain, and the body is thus unduly weighted, and tends to fall and become more or less horizontal. Moreover, the cavity being full, the vessels cannot readily pour out their contents; the body is thus more or less congested and heavy, obstruction of the mouths of the corporeal glands occurs, and there is general endometritis. The constriction being strong, the cervix follows the line of the body, the whole uterus rotating on a transverse axis at the cervico-corporeal junction, and anteversion results. Thus the rectum has become affected; the descent of the fæces depresses the cervix, lower rectal retention pushes it forward, and the ante flexion angle thus formed accentuates the obstruction. Finally the uterus is left congested, heavy, and ante flexed.

Progressive Evolutionary Disease.—The progressive evolutionary pathology, in view of the sexual activity and the great obstruction to drainage, is vigorously in the direction of endometritis, and thus to disease of the tubes and ovaries. There is pressure by the body of the uterus on the bladder, which may thus become irritable; should any descent of the uterus occur, the bladder is dragged upon, and becomes more irritable. In this causation, retroflexion is common from the dragging backward by the evolutionarily affected tubes.

(c) The third form of congenital deficiency is where the opening is normal or small, with feebly-developed body and cervico-corporeal junction, and conical or small vaginal cervix.

Mode of Causation.—At birth the body of the uterus is supported by the bladder containing urine; but on its evacuation, the bladder walls become horizontal by the abdominal pressure, and the body lies on it, so that in a feeble uterus, in which the cervix and body readily bend, an angle of flexion is formed, perhaps to be partly removed on the refilling of the bladder. But, in all directions, development is deficient in the uteri under consideration. The body is thus apt to be unduly depressed by febleness of structure at the junction of the cervix and body above the upper vesical attachment, so that an excess-

ive angle is there formed; and the vaginal cervix, also feeble, small, and perhaps conical, yields to the pressure of the rectal fæces, and takes an axis downward and forward.

The angle of flexion forms an impediment to the passage of the secretions, and the body is rendered additionally horizontal.

If the abdominal pressure be increased by tightly laced stays and weight of skirts, and, particularly if any quantity



The position of the body is normal; the cervix is anteverted.



The body is horizontal; the cervix is anteverted.



The body and cervix almost touch in anteversion.



The angle of flexion is low in the cervix from low vaginal attachment.

Diagrammatic sections of virginal anteversion with feeble development, conical small cervix, and small opening.

FIG. 10.

of food or active exercise be taken under these conditions, the depression of the body of the uterus is accentuated. Bending forward, as in writing over a desk at school, increases such abdominal pressure.

Two conditions now operate to increase the anterior apposition of the body and cervix. The first is that the angle of flexion formed at or near the junction of the cervix with the body, at about the level of the inner os, hinders the passage of mucus, so that there is some retention, and the body is heavier, and therefore tends to become more horizontal. The nutrition being feeble, congestion of the whole uterus is not marked, and there is no tendency to descent, which would be additionally prevented by con-

genital anterior shortening of the vaginal attachment which is here frequent, and facilitates some rotation of the whole uterus on a transverse axis through the cervico-corporeal junction.

The second, that the preliminary congestion of the catamenia puffs the lining membrane at the angle not less than elsewhere; and this puffing farther blocks the lumen of the tube, and increases the difficulty of escape of the increased mucus secretion in the early stage of the catamenia; and pain, irritation, and muscular contraction result, generally to be relieved by the flow of blood, which diminishes the congestive condition of the vessels and mucous membrane, and nerve pressure. The catamenial secretion thus passes the angle of flexion and reaches the cervical canal, where its progress is impeded by the small os, which difficulty is presently overcome in the same manner as higher in the canal. In these feebly-developed uteri, the sexual feeling being low, the nutrition is deficient, and the catamenial discharges small in quantity, but difficult and painful in escape, particularly on the first day. Thus the body is rendered relatively heavy and tends to fall to the horizontal position; and the cervix flexes anteriorly at the junction, or the whole uterus rotating on its transverse axis at the junction, the cervix looks downward and forward.

Progressive Evolutionary Disease.—The accumulation of the secretions, of which the drainage is obstructed by the angle of flexion and small opening, to some extent stretches the cavity of the body and produces irritation, resulting in muscular contraction, congestion, and obstruction at the mouths of the corporeal glands, which may thus become inflamed. But the fluid is, in any quantity, only periodical, as at the catamenia, and the congestion and tension are relieved by the discharge of blood. Thus the corporeal irritation is at first recurrent; and later, by frequent repetition, becomes chronic; but the whole nutrition and congestion are of a feeble character.

The secretion having been forced through the angle of flexion, reaches the cervix, where its escape is hindered by the small os, and, the same process occurring, cervicitis ensues. The cervical membrane near the opening, being thus inflamed, is thickened, and is forced downward by the pressure from above, so that it tends still farther to block the os. This may eventuate in eversion of tissue, which

may become granular. The cervical canal may thus be dilated by the accumulating cervical mucus, which escapes with difficulty either downward or upward, and its membrane is pale, anæmic, and dense.

The farther affections of the tubes and ovaries may result from endometritis; but it is most frequent that these uteri, being feebly developed from low sexual habit, undergo feeble catamenial action, which leads in the direction of deficiency and irregularity of the monthly discharge, and so to a still more diminished nutrition and atrophic state



Normal parous os.



Horizontal body of uterus from subinvolution. The canal is $3\frac{1}{2}$ inches.

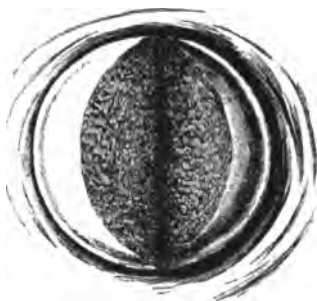
FIG. 11.

both of the ovaries and uterus. Thus intermittence of the catamenia is apt to occur, and perhaps premature menopause.

The condition continuing, the dysmenorrhea persists, the appetite is impaired, indigestion occurs, and constipation results, the fæces being delayed in the lower rectum. There their moisture is absorbed, and the purity of the blood is impaired; thence arise chlorosis, anæmia, and amenorrhœa. There are neuralgias, pains in the iliac regions, the back, the nape, and the head, general debility and malaise, pal-

pitiation, and shortness of breath. Evolutionary disease of the tubes and ovaries may occur ; but, in this anæmic state the tendency is to their atrophy.

Should marriage take place, sterility is usual ; but if, as in the milder form, where the os is of normal size, or, if small, yet gapes, pregnancy should occur, laceration of the feeble cervix is frequent, and parous antelexion results.



Cervix lacerated to vaginal junction ; the faces are everted, granular, and hyperplastic.



Horizontal body and perpendicular cervix, with subinvolution in the same.
The canal is $3\frac{1}{2}$ inches.

FIG. 12.

Unless there is laceration, this condition is cured by parturition.

(d) In parous antelexion, when the os and cervix are normal in appearance, the body is enlarged and subinvolute and is bent forward, forming an angle with the cervix and lies on the bladder ; the cavity is elongated and enlarged, the cervix tends to the perpendicular. There is endometritis, and catarrhal mucus is usually in considerable quantity.

Causes.—The virginal uterus, with a normal or strong

sexual feeling and delayed marriage, may have been ante-flexed; and after parturition, from continued weakness of its walls at the junction, it may have resumed its previous position; or in parturition the dilatation of the cervix has been normal, but puerperal septicæmia, autogenetic or heterogenetic, has occurred, and the temperature has been raised, so that involution has been impaired. Thus the body remains unduly heavy, and the endometrium is hyperplastic, the utricular glands are chronically inflamed and secrete excessive catarrhal mucus; or the binder has been continuously applied too tightly; or it may be that the repose in bed has been insufficient, and that the constitution has been previously debilitated, perhaps by excessive child-bearing, or by organic disease as phthisis; that there has been over-suckling; that the work undertaken has been premature



Section of laceration of the cervix, with great hyperplastic granular eversion of both lips, particularly the anterior. The uterine body and cervix are horizontal.

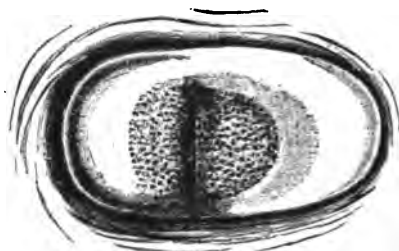
FIG. 13.

and excessive; or that gayety and tight-lacing, and weight of clothes, effect the same result. Previous endometritis from gonorrhea or other sexual cause may not have yielded to the natural tendency toward health in the period of involution.

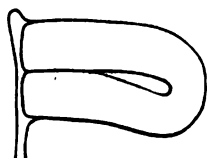
Mode of Causation.—The mode of causation is that, sub-involutionary endometritis persisting, the body of the uterus is unduly heavy and is deficiently supported by the subinvolute broad ligaments. Therefore it falls, and, the tendency being to the anterior direction, it creates an angle in some degree with the cervix; but as the body is supported by the bladder and approaches the pubes, particularly if the abdominal walls be lax, it rests on it, and there is no de-

scent, and the cervix is not pressed forward in an inferior axis of the pelvis.

Progressive Evolutionary Disease.—The condition is that of chronic subinvolutionary endometritis and slight angling of the canal, which does not impede drainage, and there is no granular source of irritation at the cervix. The angling does not impede arterial entrance of blood, but may retard the venous return, whereby the body continues heavy, and pressing on the bladder may irritate it and induce frequent micturition. The angling of the tubes at the cornual junction.



Deeply lacerated cervix with flattened hyperplastic granular face and everted hyperplastic cervical tissue of anterior lip.



The same, showing the flattening of the everted lacerated lips against the posterior wall, and anteversion with subinvolution.

FIG. 14.

tion being of a moderate degree, apart from antecedent tubal affection and the influences of abdominal pressure, no ulterior affections occur.

Mode of Causation.—Pregnancy in the case of a small vaginal os and anteversion, frequently with endometritis, is not apt to occur. But the endometritis may be of a mild character or be absent, the opening minutely agape and the semen may enter, it may be, after lapse of a long period of marriage. The development of the cervix in pregnancy

takes place and the part is prepared for labor. The well-developed cervix, though with a small opening, often normally dilates without laceration; but the small conical cervix of feeble development, and the small opening with granular eversion and connective tissue hyperplasia, are frequently the causes of the rigid cervix, and almost invari-



Virginal conical cervix, an pinhole os in an otherwise strongly developed uterus.



Anteversion of the same.



Virginal normal face and opening after resection.

FIG. 15.

ably rupture rather than stretch; and this may be under the use of the forceps, which the necessity of the condition may compel. Any other condition of previous laceration may induce similar results. In these states the edges of the raw faces are pulled apart laterally by the torn circular muscular fibers, and on the inferior borders by the retracting longitudinal fibers, and the raw faces are also separated



Vaginal
rubbed
the lips.

ed, but anteverted uterus with very small opening and
granular face and areolar hyperplasia compressing



Diagram of anteverted uterus. The cervix is anterior, the body normal.



The same after operation by resection.



Diagram of the same uterus after operation.

FIG. 16.

by the lochia and do not unite; the drain of their discharge is sufficiently enfeebling to hinder involution, so that the body remains unduly long, large, and heavy. Should they become septic and the temperature rise, the healing and absorptive processes are the more prevented for it is difficult for the tissues to heal by first intention as an increased heat. The processes are accentuated by the pressure of a tight abdominal binder. The body thus assumes a horizontal position, or resumes the pre-parous state of anteflexion, though by the development of pregnancy the dilatation of labor the cervix may cease to look forward and downward, and may present rather downward. The endometrium does not complete its involution, but degenerates into a state of low hyperplastic endometritis, with abnormal excessive secretion from the utricular glands, and there is continuous irritation of the raw lacerated cervical faces against the vagina.

Progressive Evolutionary Pathology.—The anteflexion is coincident with the laceration, subinvolution, and endometritis; and the progressive tubal, peritonitic, and ovarian disease thereof has been previously described. The uterus, being thus unduly heavy, and its supports deficient in power by the general subinvolution, is depressed, and may sink in the axes of the pelvis with rotation on a transverse axis through the cervico-corporeal junction, rarely seen except in deficiently developed uteri; but usually the body rests anteriorly on the bladder toward the symphysis, and is thus supported. The pressure on the bladder may produce irritability, congestion, and evolutionary results. If the laceration extend deeply into the broad ligament, particularly with an adherent tube, distention of the bladder, by producing irritation in the angle of the rupture and tension on the adherent tube, may induce frequent and painful micturition and congestion of the bladder. General debility is usual.

The mechanical and pathological story of the generative organs, especially of the uterus, and their relation to the topic under discussion, is well, faithfully, and technically related, but the greatest and most subtle causes of these malconditions are yet to relate:

The influence of dyscrasies in weakening the uterine sup-

ports, vaginal, rectal; and the ligaments of the viscera of the entire abdominal cavity, as well as the relaxation following frequent excitements of the sexual organs, and of the great sympathetic nervous system.

Clear in his conceptions of the mechanical and pathological causes, the author is blind to the vaster influence of a great vital force, intimately related and subtly controlled by the reflexes of the sympathetic, which acutely evidences all unnatural and morbid conditions as well as all diverted forces.

As shock is to the great sympathetic with its influences upon the special organs when susceptible, as we witness in instantaneous vomiting, diarrhea, hemorrhages, and even in abortions; so are the milder but constant effects upon the organs which pervert their function which is reflected by the great sympathetic, with resultant debility of the whole organism, but especially the organ primarily excited or injured, either by diverted or impoverished nutrition, or mechanical abuse, accidentally or purposely (though perhaps ignorantly) indulged.

When girls are found to so indulge this sensual habit, at from six to eight years of age, may we not know that the cause of "marked sexual activity" may have been induced by premature excitation, just as we would look for marked development of any other organ, or muscular development?

The conditions related by the Dr. Headl are of secondary interest; the primary objects are the systemic conditions which weaken the supports as well as the organs. Neither corsets nor ball-room habits of dress, nor constipation, nor all of these, are to blame wholly for these malpositions. Many of the best examples of strong uteri and strong characters are found among the vivacious society people who have been well trained in youth by a wise mother, guardian, nurse, or by force of surrounding environment, which has taught them early the lesson of intellectual and physical development. These being well attended to

in youth, the sensual will be more enjoyable as Nature intended, with the absolute avoidance of the greater causes of "Anteversion and Anteflexion," as well as all other causes except those of accident or those due to consanguinity and exposures.

You may say that a knowledge of the mechanism and pathology alone is sufficient for the treatment and cure of these difficulties. I answer that a treatment based upon these principles alone makes more invalids, and gives me more than half my patients. The phenomena presented and reflected by the various constitutions, peculiarities, and idiosyncrasies, together with the pathological and mechanical condition, are to be considered. We not only find it necessary to know pathology and understand and use the various devices and mechanical aids and manipulations, but we must know how to use symptomatology in the application of proper therapeutics for the cure of the condition predisposing to these malpositions.

A NEW METHOD OF DILATING WITH FARADISM.

BY

JENNIE W. MARTINE, M. D.

THE method to which I desire to call your attention is, I believe, new, I at least never having heard of it, though there may be others who have practiced it.

The important point in its consideration is that, being painless, it frequently obviates an operation where anæsthetics are usually employed, which the experienced practitioner especially desires to avoid in the case of the nervous patient. As divulsion is of absolute importance in treating many diseases of the uterus and appendages,—

thorough drainage being a necessity in the cure and the benefit only to be obtained by dilating,—a simple, painless method of arriving at this result, without discomfort to the patient, must prove of value.

This method had its conception through the employment of intra-uterine applications of faradism; the instrument being a common sound, insulated to, within two inches of the point, by means of a piece of ordinary rubber tubing; these agents, being always at hand, readily cleansed, and never getting out of order, have answered my purpose until recently for intra-uterine treatment.

In the use of the simple instrument above described, I found the necessity of constantly increasing the strength of the current, as patients failed to feel it after a few minutes, proving its numbing effect. Knowing this, I therefore decided to utilize it, which I have done, and submit the results to your professional notice in this paper:

Thorough tests with both the galvanic and faradic currents have led me to the conclusion that faradism is preferable to galvanism in this connection, the galvanic at times producing an irritation without the numbing effect, this being frequently followed by inflammation. Faradism, on the other hand, brings about the necessary anæsthesia without irritation and consequent danger of future inflammation.

To accomplish the required result in these cases, the coil must be of particularly fine wire and more than the usual length. Of two batteries in my offices, apparently similar, each answering admirably for ordinary purposes, the one readily produced anæsthesia, while the other has absolutely failed: investigation has proved that the latter coil is neither of the fineness nor length of the former.

Manufacturers within the past few years have been furnishing the requisite coils for special cases, under the intelligent direction of the experienced electro-therapeutist, thus facilitating the use of that agent.

In cases of dysmenorrhea due to stenosis, congestive or

otherwise, a small sound was first introduced, in some cases only a probe, and though the rubber tubing at times proved too large, it fitted tightly over handle where contact with rheophore was made by slipping the metal point under the rubber, which held it securely and gave the necessary insulation.

The other rheophore being attached to pad on abdomen, after a few minutes this instrument was withdrawn, care being taken that current was first turned off; a size larger was then carefully introduced and current again turned on, this method of procedure being continued until the necessary dilatation was obtained.

The operation is absolutely similar to that of divulsion without electricity. Success, however, by this method cannot always be attained, for when the stenosis is marked, it is at times impossible to introduce even the smallest probe, especially where flexions occur.

A case that did not yield readily to the treatment first described suggested the use of the Nott dilator attached to a rheophore. In using this instrument, it being of course necessary to render it non-conductive—and rubber tubing not slipping over handles owing to connecting rivets—I obtained it by winding them with a two-inch strip of rubber bandage, to within three inches of the points, care being observed not to interfere with the necessary opening and closing of the instrument; one rheophore, as I before remarked, was attached to the dilator, the other to pad on the abdomen.

The dilator, closed, was introduced into the cervix, and after the numbing stage was reached the dilator was gradually distended, and the object was attained. Before realization, the internal os had been passed and entrance had been effected into the uterus, the patient experiencing neither pain nor shock.

This constitutes what I am pleased to consider my discovery.

Its frequent use in practice has convinced me of its great value.

Flexions, etc., at times complicate matters, but the gradual and moderate stretching of the parts at frequent intervals has never failed to eventually give entrance and permit the proper treatment.

The faradic current produces a wonderful elasticity of the parts aside from its anæsthetic effect, equaling if not exceeding galvanism. Continued success with faradism, however, may have prejudiced my opinion in its favor.

If the current fails to flow during the period of dilatation all anæsthetic effects are lost, the anæsthesia being but temporary.

Warning! from experience. Do not attempt force in the introduction of the instrument, as rupture of the organ may result; prior use of the probe will give absolute certainty as to the position of the uterus and thus obviate this danger.

The introduction of the dilator is seldom obstructed until internal os is reached, so that the slightest force may unwittingly cause serious injury, especially in cases of version or flexion.

While tenacula would undoubtedly prove of service in holding uterus, they are impracticable without an assistant.

This method can be readily applied with or without the speculum. The speculum being preferable, however, as it allows complete observation of the parts. Particular care must be exercised regarding the insulation of the dilator where contact with the speculum occurs.

My instruments are perhaps crude, as my description of them has informed you, but I have now in course of manufacture those that I hope will be nearly perfect for this purpose, and concerning which you will probably hear from me later. The old ones have answered until recently, and in the worry of practice the importance of special instruments has but recently claimed my attention. In connec-

tion with the dilator, etc., I am having made a set of graduated sounds, following the idea of the Hanks' hard rubber dilators, but with proper metallic connections.

In the application of the foregoing method, condemnation should not follow failure, until the quality of the coil used has been ascertained; the current of great intensity only being obtained from the coil I have mentioned, and being the one necessary to produce the anæsthetic effect required. Much experience with many cases has brought conviction regarding its value; cures have been effected that yielded to no other treatment. Endometritis also falls within its scope. In these cases dilatation proves easy, because of the lesions, and the intra-uterine medications as indicated are then easily made, not even a powerful caustic causing pain.

The drainage which is also so necessary to a cure is thus obtained, the electricity stimulating the parts to normal action.

In stenosis the divulsion, because of its gradual accomplishment, proves permanent, there being no rupture of the membranes, such as may follow the ordinary process of rapid dilatation under ether; cicatricial tissue is thus avoided, which, as every surgeon knows, frequently proves an active factor in subsequent contractions.

In stenosis it is certainly better to continue treatment until two menstrual periods have been passed without pain.

The Nott dilator has been the only one used by the writer of this paper. Other dilators might undoubtedly answer the purpose, but the Nott, because of the smallness of its diameter when closed and being more pointed, has seemed preferable to all others, though the danger of perforation is greater owing to these facts, but in my experience its careful use has proved effective.

There may be cases that fail to yield to this local treatment, but I have yet to find one, and those of my profes-

sional friends who have tried it have only a favorable report to make, and have dubbed it the "Martine method" of dilatation.

Through the crudity of my ideas flits the seeming chimera of perfect electrical anæsthesia, and if my premises are correct, why cannot curettement be also done by this method, care being taken to "make haste slowly"?

With the confidence born of its previous successful use, that only good will follow its publicity, I submit this method to your professional consideration.

A SYMPOSIUM UPON DIET AND TREATMENT DURING CHILDBIRTH.

BY VARIOUS AUTHORS.

Any instruction as to diet ?

Forty-five answer, yes; ten, no.

Plain, generous diet.—*Dr. R. Kingman.*

Not unless called for by abnormal conditions.—*Dr. J. D. Jones.*

Encourage use of fruit and vegetables; meat once a day; scarcity of bread.—*Dr. J. M. Smith.*

Mixed diet, green vegetables, meat, and fruit.—*Dr. J. K. Sanders.*

I believe in a simple, generous, easily digested, mixed diet.—*Dr. S. H. Knight.*

If necessary, I advise limiting meat, using milk and vegetable diet in abundance. By vegetable, I mean non-nitrogenized.—*Dr. F. P. Batchelder.*

No; except that I strongly advise eating anything the market affords that is desired.—*Dr. E. E. Reininger.*

If albuminuria present, no meat; but milk, fruit, cereals, and vegetables. Usually allow meat only once a day the first three months.—*Dr. C. T. Canfield.*

Do not eat meat.—*Dr. W. D. Foster.*

Salt food preferred.—*Dr. R. N. Foster.*

A bite before rising ; light, frequent lunches rather than hearty meals.—*Dr. C. F. Martin.*

I permit the patient to eat whatever the appetite craves and the stomach digests, provided it be not an abnormal craving.—*Dr. W. M. Bailey.*

Eat what she craves. If no craving for anything in particular, give plain nutritious food.—*Dr. C. G. Higbee.*

Chiefly fruit and vegetables ; beef, mutton, or game once a day not objectionable.—*Dr. V. A. Watson.*

General, not much ; but if previous history shows dystocia from too hard bones of head and shoulders, then I order acid fruit diet for two, or better, three months.—*Dr. A. L. Fisher.*

Eat grains, fruit, eggs, milk, and sparingly of meats.—*Dr. L. Allen.*

Increased quantity of fruits, if possible, and tender meats.—*Dr. F. D. Brown.*

Usually recommend meats and fruits, with avoidance of heavy cereals, sweets, and fats.—*Dr. M. D. Youngman.*

Only such as tends to keep the bowels regular.—*Dr. Ridgewood.*

No meat last three months.—*Dr. M. Branson.*

Not much sugar or starchy foods or meat.—*Dr. J. T. Smith.*

Mixed ; as much fruit as possible, with avoidance of beef and potatoes to excess.—*Dr. C. L. Nichols.*

Any advantage derived from fruit diet ?

Twenty-three answer, yes. Twenty-two answer, no.

Makes labor easier and not so tedious.—*Dr. J. T. Thatcher.*

Never have been positive of any result from fruit diet.—*Dr. J. M. Smith.*

Not from exclusive fruit diet.—*Dr. J. K. Sanders.*

Decided advantage when considerable fruit is taken with and between meals.—*Dr. F. P. Batchelder.*

Used fruit diet in primipara of advanced age—over thirty years.—*Dr. A. Berghaus.*

Do not recommend it. Think it wrong to limit diet to one line of food.—*Dr. E. E. Reininger.*

Yes; if used judiciously.—*Dr. C. T. Canfield.*

Sometimes, in cases of constipation. Otherwise, I doubt it.—*Dr. G. F. Martin.*

I have never seen any special benefit from the use of fruit as a diet.—*Dr. A. W. Cushing.*

I have seen it tried in but one case. The accouchement was very easy. The labor required night and day for months after to soothe and quiet an irritable and crying baby, who seemed to continually want something that could not be supplied it, discouraged me from experimenting further with the fruit diet.—*Dr. C. G. Higbee.*

No perceptible advantage in my cases.—*Dr. R. D. Wilson.*

Prescribed it once, in primipara, æt. forty, and think labor would have been easy but for presentation being interfered with by cord, I think, over neck, and used forceps; child does not thrive, and colicky.—*Dr. A. M. Duffield.*

Yes; when we have reason to fear too hard head—the acid fruit diet prevents excessive bony formation. But if this diet is rigorously adhered to in all cases indiscriminately, you will produce a very scrawny lot of babies.—*Dr. A. L. Fisher.*

I believe fetus weighs less, is more “scrawny”; birth easier.—*Dr. M. D. Youngman.*

None known in my own practice.—*Dr. J. F. Smith.*

Tends to make healthier children, and makes childbirth easier.—*Dr. E. Everett.*

An exclusive fruit diet is pernicious to the last degree.—*Dr. A. Berghaus.*

Bones more pliable.—*Dr. J. F. Smith.*

Never noticed any. Have tried a few cases with it.—*Dr. G. E. Tytler.*

Not enough to counterbalance the weak and ill-nourished children resulting from strict fruit diet.—*Dr. C. L. Nichols.*

Yes; to mother—not to child.—*Dr. G. M. Ockford.*

Mention remedies most used in promoting dilatation in order of importance, and reasons?

The figures give the number of times each remedy was mentioned: gelsemium, 29; belladonna, 29; cimicifuga, 18; caulophyllum, 12; pulsatilla, 9; causticum, 2; lobelia, 2; quinine, 1; antimonium tartrate, 1; chamomilla, 1; cocaine, 1; aconite, 1; chloroform, 1; chloral, 1.

Atropine, generally; the remedy hypodermatically.—*Dr. Jones.*

Lobelia, belladonna; I give lobelia on general principles derived from Thompsonian era.—*Dr. Geo. M. Ockford.*

Cimicifuga, belladonna (and oil); as indicated by proved remedy.—*Dr. J. M. Smith.*

Have not used remedies very largely lately, as it seems to me that more can be done by varying positions.—*Dr. A. M. Duffield.*

Belladonna and cocaine tampon (small) to the os.—*Dr. A. Berghaus.*

Gelsemium in twenty drops doses.—*Dr. Ridgewood.*

In five cases out of six, I get my indications for remedies from other symptoms.—*Dr. A. H. Tompkins.*

No medicines have proven of any value with me.—*Dr. W. D. Bayley.*

Belladonna, lobelia, *ad nauseam*, in obstinate cases.—*Dr. J. H. Smith.*

Gelsemium, cimicifuga, belladonna ointment to cervix. Pulsatilla, θ gtt. xx, aqua, ℥ ij; teaspoonful every half hour or less, on "general principles," as oxytotoxic.—*Dr. M. D. Youngman.*

Caulophyllum θ , or macrolin ix, because they act on the

muscles of the fundus uteri; cham. 2x, nervous, irritable persons, rigid os.—*Dr. L. Allen.*

I do not depend upon remedies much, but occasionally give belladonna or gelsemium. The former, if there is much cerebral congestion. If pains have been exhausting, with nervousness, I give a hypodermic injection of $\frac{1}{4}$ grain of sulphate of morphine; let the patient sleep a few hours, when she will awaken and go at it in earnest.—*Dr. E. J. Jones.*

The best remedy is that which covers the totality of symptoms in its broadest sense. The remedy which most improves general condition.—*Dr. V. E. Watson.*

Gelsemium, for rigidity; cimicifuga, nervous irritability; belladonna, rigidity in plethoric patients; caulophyllum, when pains are irregular and weak.—*Dr. J. M. Ward.*

I have placed very little reliance on internal medication, perhaps giving a few times belladonna and caulophyllum.—*Dr. C. G. Higbee.*

I have given caulophyllum at night and cimicifuga in the morning, each 3x for two or three weeks before confinement, and I think with marked benefit at time of labor, the parts being less rigid.—*Dr. E. M. Cushing.*

Opium θ , 1 grain; it has always worked like a charm, relaxes the whole symptom, dulls the pains, and quiets the patient's nerves.—*Dr. Kate L. Hickox.*

Caul., puls., gels., actea, bell. The remedy is most important in a given case which is clearest indicated in that case.—*Dr. G. F. Martin.*

Have little use for or confidence in such remedies, because digital dilatation is all that is necessary.—*Dr. R. N. Foster.*

Gels., bell., tart. emet., because most frequently indicated.—*Dr. C. T. Canfield.*

I can hardly do so, as nearly every case is peculiar to itself, and treat accordingly; besides I rarely have *any* trouble in that way.—*Dr. E. E. Reiningger.*

I have relied upon *caulophyllum*.—*Dr. J. K. Warren.*

Have prescribed for symptoms regardless of dilatation.—*Dr. A. Berghaus.*

None of much good; if any, belladonna, gelsemium, *cimicifuga*.—*Dr. O. B. Sanders.*

Hot water vaginal enemata I regard as superior to drugs; also hot hip bath.—*Dr. F. B. Brown.*

Gelsemium; antispasmodic, and dilates circular fibers.—*Dr. O. L. Wood.*

What mechanical means?

Hand only, twenty-eight; Barnes' dilators, four; none, sixteen; Pratt's dilators, one.

None, except when rapid dilatation is needed; then use Barnes' or M'Lean-Barnes' dilator.—*Dr. J. K. Sanders.*

Have had no occasion to use any, except hot sitz baths and hot enemas. Have never advised hot douches, since they bring away the mucus, which acts as a natural lubricant.—*Dr. F. P. Batchelder.*

In labor at full term have never resorted to mechanical means.—*Dr. C. F. Canfield.*

None in normal cases. If too protracted, hot douche; sometimes wedge of fingers or Barnes' bag.—*Dr. G. F. Martin.*

I generally begin as early as I can during labor to dilate the soft parts by introducing the finger well into the vagina, with the thumb over the coccyx; then during a pain, gentle pressure is made, but not enough to disturb the patient. This will dilate the soft parts, gradually making it easier to make any examinations as to position, etc., and it changes the character of the pains, more like straining at stool, doing more good, and they are better borne, and it prevents laceration later. To dilate the os uteri, I dilate with the finger if I can, and as the soft parts are dilated it can generally be done; but if not, I introduce Loomis' placenta forceps, and dilate gradually often changing their position, so as not to rupture any part.—*Dr. W. A. Cushing.*

Hip baths; use of the fingers; and more frequently than all other measures, when dilatation was slow and dilating pains feeble, I have found that rupture of the sac of waters greatly expedited dilatation. Of course, I would not use this measure in a rigid os, but where the dilating pains are inefficient, frequently due either to feeble uterine contraction, or to irregular contractions, or contractions that are not rhythmical, it is a very efficient measure. In some of these cases the patient is hyperesthetic, the pains spasmodic, and then chloroform has afforded me the greatest help.—*Dr. C. G. Higbee.*

Seldom resort to mechanical measures to great extent to hasten dilatation of os. A couple of fingers within os, exerting a few pounds pull during absence of pain, seems to aid sometimes, especially when anterior lip is too long or os pointing too far back.—*Dr. A. L. Fisher.*

None have been required in over three hundred cases.—*Dr. J. H. Smith.*

Sweeping with the finger, stretching with index finger of both hands.—*Dr. W. D. Bayley.*

The fingers hooked in the os sometimes.—*Dr. A. H. Tompkins.*

The finger used carefully in a circular direction to prevent laceration.—*Dr. C. L. Nichols.*

APPLICATION OF THE FORCEPS.*

TRANSLATED BY

B. F. UNDERWOOD, M. D.

(Continued from p. 153, March, 1896.)

EXTRACTION.

WHAT remains to be done with the forceps to terminate labor?

The descent of the head is to be completed, rotation accomplished, the head brought through the inferior strait and into the soft basin, and finally delivered outside of the vulva.

(a) Completing the descent. By a moderate, but continuous, traction made in the axis of the blades and in the known axis of the pelvic cavity, the head, if it is not already there, is to be brought to the pelvic floor. If there, as in the position supposed, it is to be retained in position by traction, at the entrance to the inferior strait until the resistance has been felt and the distention of the posterior perineum observed.

It has already been shown (pp. 273 and 283, May, 1895) how to use the forceps of Levret and the forceps of Tarnier.

(b) Rotation. When, and only when, the descent of the head has been completed and the perineum distended, traction being continued, a slight movement of rotation, if it has not already occurred of itself, is to be imparted to the forceps, to the end of bringing the nape of the neck behind the pubes, the occiput under the symphysis. The left blade will come directly to the left, the right blade directly to the right. This movement will have been completed when the handle of the left blade will have passed to the right, the handle of the right blade to the left, their

* From the French of Professor Farabeuf and Dr. Varnier.

hooks being directly across. (Transformation of fig. 32 into fig. 33.)

This movement of rotation of the blades, and consequently of the head which they hold, shown in fig. 34, is accomplished by imparting, from the ends of the fingers to the extremities of the handles, to the hooks, a circumduction about the longitudinal axis of the head, axis parallel to that of the blades. In the present case, left occipito-

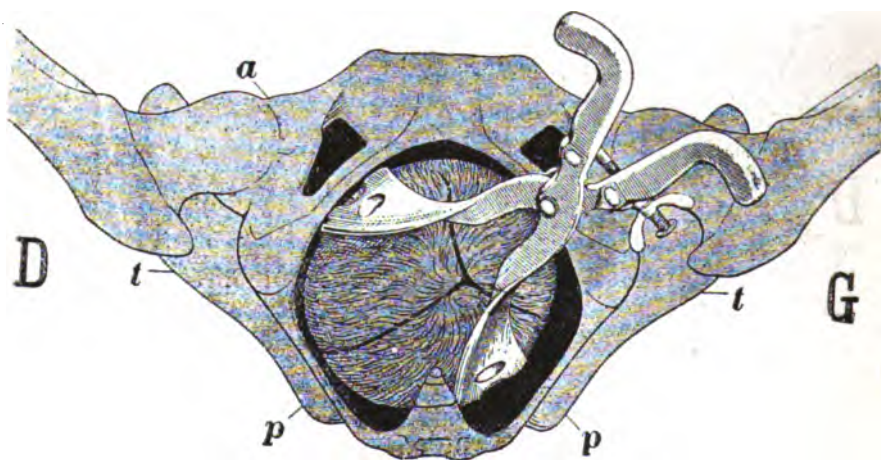


FIG. 32.

anterior position, the hooks, setting out from this same position, describe an arc of 45° and stop upon the median plane, in a pubic position corresponding to the occipitopubic position which the head has taken. (Figs. 32 and 33.)

Fig. 32.—Vertex at the inferior strait in the left antero-occipital position. The forceps have been applied, articulated, and locked. The figure represents the point of departure of the rotation, which will carry the occiput, and consequently the handles of the forceps, directly in front.

Fig. 33.—Vertex at the inferior strait in the direct anterior position, the result of the rotation of 45° sustained

by the head, shown in fig. 32. Now the passage of the strait, etc., is carried on under the influence of traction.

(*c* and *d*) Engagement in the soft basin and emergence outside of the vulva. As in the direct application to which reference has been made, it still remains to engage the head in the soft basin, and by almost horizontal traction to

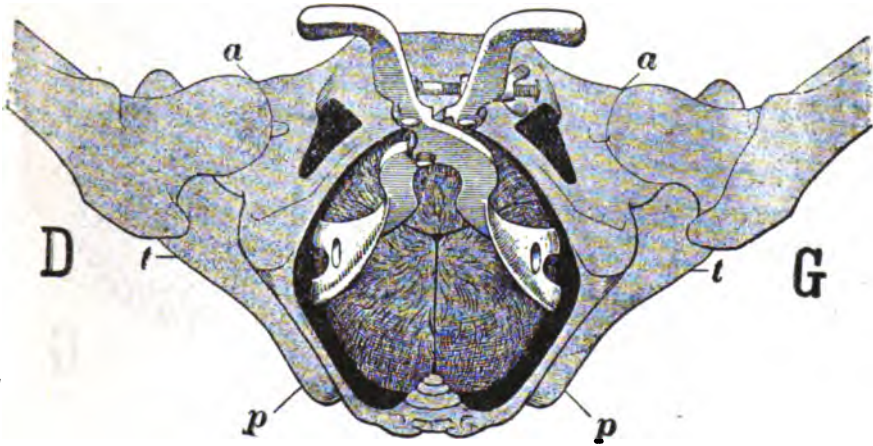


FIG. 33.

make it traverse the soft basin and pass the vulva, progressively changing the traction toward the vertical.

LEFT TRANSVERSE APPLICATION.

Vertex at the inferior strait in left transverse occipital position. The flexed head has descended, more or less deeply, into the pelvis, generally nearly to the inferior strait. But it has not yet engaged, for rotation is far from being made.

The occiput is directly to the left, the bregma directly to the right. That is to say, the transverse diameter of the cavity is occupied, according to the degree of flexion, by the sub-occipito-bregmatic or sub-occipito-frontal diameter

of the head, and the antero-posterior pelvic diameter by the bi-parietal. This places one ear in front, the other behind, and in the same way one parieto-malar line in front, the other directly backward (fig. 35).

The mother, in obstetrical position, presents the face of the plane of the inferior strait, but the head being yet in the axis of the excavation, it is the anterior parietal line, here the right, which will be seen through the vulva: the sagittal suture, transversely directed, is deeply—more posterior—accessible to the finger, but invisible. The posterior parietal line, to which the first blade is to be applied, is deeply hidden in the concavity of the sacrum, in front of which it rises nearly to the superior strait. Between the side of the head and the concavity of the sacrum there is plenty of space for the hand.

The head is to be taken in length, and by the sides, the concavity of the forceps being turned toward the nape of the neck, which is to be brought upon the median line. It is to be borne in mind that the nape of the neck is directly to the left; that of the two sides of the head, the one is directly anterior, the other posterior; that the grand axis of the head has its extremity—its descendant pole—still greatly posterior.

Knowing this, as preliminary exercise hold the forceps upon the outside, in both hands, in the position or attitude which they will have when the head has been properly grasped, and (aided by fig. 35) establish:

The left transverse direction of the pelvic concavity of the instrument, that which throws the handles upon the same side as the concavity of the forceps and the occiput; the left branch, the highest, held in the left hand, has its blade the lowest, to enter posteriorly in the sacral concavity, embracing the posterior parietal line; and the right branch, the lowest, held in the right hand, carrying the blade in front, behind the pubes, to be applied to the anterior parietal line.

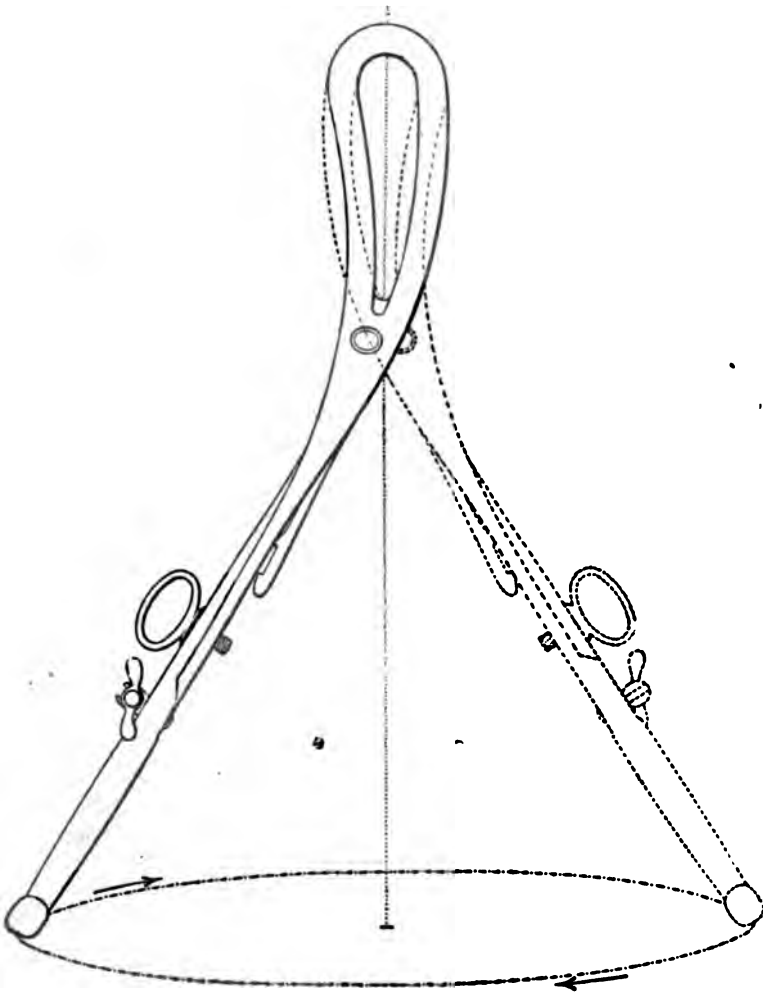


FIG. 34.

FIRST GENERAL RULE.—It is necessary to introduce first the blade which will be posterior, in order to have all facilities to place it properly, for upon the proper placing of this blade depends the success of the operation.

It is the left blade in this position, the left occipital transverse.

SECOND GENERAL RULE.—The blade introduced secondly can only be placed above the first. Therefore its handle will necessarily cross that of the first.

In the present case, the left occipital transverse position, the right blade, introduced second, is the female, the notched: crossing over the first, which is the male,—the pivoted,—will properly offer the notch to the pivot of the former. Therefore the left branch, pivoted, held in the left hand, should be applied the first, preceded and guided by the right hand. This blade is to be introduced, and placed at the first onset, flat, on the median line, backward.

Supposing it to be properly introduced and kept in place by an assistant: the right blade, notched, grasped in the right hand, should then be brought, the blade in front, in a symmetrical position to that first introduced. But it will not be possible to introduce it at the first onset to the position which it should occupy. It will be greatly out of position.

It is posteriorly only that there exists, largely extended, it is true, a space capable of receiving the indispensable guiding hand and the blade. It will be, therefore, posteriorly, and to the right, to the side of the blade first placed, and above, that the left guiding hand will be introduced, and the right blade.

In this manner the second blade will at first encircle the temple or posterior half-frontal diameter. To bring it in front, upon the anterior parietal line and the cheek, near to the anterior ear, it is necessary that, without ceasing to be properly applied to the cephalic ovoid, it may pass, on the side, where the hand still remains, from its initial position,—oblique posterior,—to a point where it will come directly in front opposite to the blade first introduced. It is in this movement that it has greater extension: three times 45° —the movement of Mme. Lachapelle.

The blades of the forceps should now spontaneously articulate, provided that the assistant charged with maintaining the position of the first branch has not committed the fault of allowing it to slip from its place.

The position of the head upon which the instrument is to be applied being known, you come, forceps in hand, and figure them introduced and properly placed—the first branch, the posterior (left, pivoted. branch of the posterior

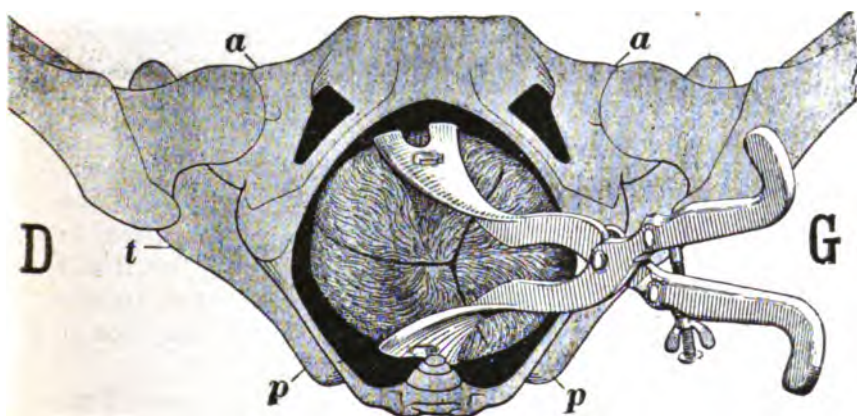


FIG. 35.

ear; and the same way, the second branch, the anterior (right, notched, branch of the anterior ear), introduced posteriorly to the right and brought in front. As in all cases, separate and sterilize the forceps, having them well lubricated upon the convex surfaces of the blades.

Fig. 35—Vertex at the inferior strait in left transverse occipital position, having the forceps directly applied—left blade (pivot) directly posterior, right blade (notched) directly in front. Coccyx figured as already pressed backward.

OVARIOTOMY AT THE EXTREMES OF LIFE.

BY

GEORGE BURFORD, M. B.

I HAVE frequently demonstrated the easy and uneventful character of recovery after uncomplicated ovariectomy; a convalescence smoother and more uniform than that of any idiopathic disease after crisis. The extremes of youth and age scarcely color the easy progress of restoration to health; and the ensuing cases I have selected as object lessons of the mild stress which simple ovariectomy imposes upon the bodily powers.

I.—*Ovariectomy on a Patient at Sixty-two Years : Unusually Rapid Convalescence.*—Dr. Neild of Tunbridge Wells referred to me an elderly lady with an ovarian cystic growth for operation. So insidious was the development of this tumor that the patient had assigned her increasing bulk to flatulent dyspepsia, which latterly had constantly troubled her. Not content with the patient's diagnosis, Dr. Neild at once instituted a thorough examination of the vital organs, and discovered a large ovarian cystic mass, which up to that time had been unrecognized.

The lady was sixty-two years of age, tall, spare, and, with the exception of the dyspepsia, in moderately good health. The sphygmographic tracing showed arterial rigidity rather than high tension; the sp. gr. of the urine was 1010, and the quantity per diem about 40 ounces. I look upon the presence of a low sp. gr. of urine, no less than the presence of urates, as a condition to be amended before safe operation; and I was gratified after a few days' careful dieting to observe the sp. gr. rise to 1020, with but little diminution in the fluid excretion. Arnica was the remedy administered during this time.

The operation presented no condition of difficulty. A

large multilocular ovarian cyst was removed, springing from the left side, and, to make assurance doubly sure, the serous cavity was washed out with warm water, and a glass drainage tube inserted. This latter was removed in less than thirty-six hours. There was no shock, and the pulse was as good at the end of operation as at the commencement.

Flatulence and vomiting caused some trouble for a couple of days, but these were then subdued by a few doses of merc. dulcis *ix*. Thereafter the convalescence proceeded almost without interruption. There was no pain; the patient slept well, and asked for and obtained solid food sooner than in similar cases is the rule.

Some bladder irritation now declared itself, and was treated by irrigation, combined with the internal administration of nitric acid *ix*. Save and except for this incident the recovery was unbroken; the incision healed by first intention, and it was with the greatest difficulty that the patient could be induced to submit to the routine nursing of an ovarian case. Her high spirits were continuous, her bodily strength rapidly increased, and she returned home exactly eighteen days after operation, having made a convalescence which, for brevity, is in my experience a record one. So far as the dyspepsia was concerned, the patient had lost the heavily furred appearance of the tongue which up to operation had been persistent.

II.—*Ovariectomy on a Patient at 15½ years; Uninterrupted Recovery.*—Dr. Joseph Kidd sent to me at the hospital a girl *æt.* 15½, with a large ovarian cyst, for ovariectomy. The patient was tall and otherwise slender, in fair health, excepting for abdominal pains, which had recurred at lessening intervals for some six months.

The menstrual period had been initiated a year before, and had recurred regularly at monthly intervals up to four months ago, when the interval had been curtailed to a fortnight; and she had menstruated twice each month since that date.

Abdominal examination revealed a large ovarian cyst, which responded to all the classical indications of thrill, percussion, dullness, fluctuation, and localization. On consultation, ovariectomy was unanimously recommended.

The operation resolved itself into the removal of a large monolocular ovarian cyst by abdominal section, through an incision scarcely exceeding two inches. The cyst sprang from the left side, and its interior lining was found coated with small calcareous plates. No drainage was requisite.

The convalescence was practically without break, and the incidence of the operation was singularly slight upon either the vital powers or the comfort of the patient. Twenty-five days was the term of her stay in hospital after operation, and this period could have been abbreviated had we not thought it advisable, in view of her tender years, to maintain a somewhat longer supervision than was absolutely requisite.

The patient was sent to the Convalescent Home at Eastbourne to establish her health, and on returning to town reported herself to me, and afterward to Dr. Kidd, in excellent health. The menstrual period had now resumed its monthly type, and I had no hesitation in advising the early resumption of her active duties.

SOME CAUSES OF PELVIC INFLAMMATION.

BY

A. V. SWETLAND, M. D.

IN this article I propose to consider some causes of pelvic inflammation. We know that chief among these are injuries to the cervical canal during parturition, especially lacerations of the cervix uteri. We may often have inflammation without laceration, but serious lacerations of the cervix are sure to be followed, sooner or later, with inflammation in a chronic form.

In a close study of ovaritis we find it is an inflamed state of the uterine membrane, carried through the tubes to the ovaries; following out the observation on the side of the laceration, we have the one-sided headache and stomach irritation, a numbness extending through the fingers and toes on that side, almost invariably followed by extreme nervousness and hysterical tendencies.

Usually the hysterical form of nervousness is from the ovarian inflammation; it is difficult to differentiate between pelvic inflammation and ovaritis; in the ovaritis there is sensitive, sickening pain, while in the lower pelvic organs we have more nausea.

When we have the perineal lacerations only, we have the head troubles without the stomach irritation. A lady who came under my treatment a year ago had been constantly treated for dyspepsia and liver trouble, complained of head and stomach, complete prostration of mind and body. Upon examination found deep cervical lacerations of the cervix, uterus congested and retroverted, the ovaries congested, tender, and painful—entire perineal laceration. I found that medication was of little avail, the prostration still continued. When the conditions were improved by surgical repair, she made a rapid recovery. There was no effect whatever on the ovaritis until after this. She is now well and strong. Other serious causes of inflammation are cold water douches and rubber pessaries to prevent conception, resulting in dysmenorrhea, leucorrhea, and menorrhagia; these also causing ovaritis, and, through the nervous system, irritation of the stomach and hysterical tendencies. Another cause of inflammation, and I find it quite frequently, is this constant dread of motherhood, which depresses the entire nervous system, especially the nerves of the genitive organs, causing a chronic inflammation, which is almost impossible of cure by medication, as medicine will not remove the cause; this must be removed by education.

DIARRHEA OF INFANTS AND CHILDREN.

BY

W. R. STEWART, M. D.,

THIS affection has had a variety of technical names given it by various authors. Those who look for a name in the cause have styled it summer diarrhea, teething diarrhea, mycotic diarrhea, fermentative diarrhea, and dyspeptic diarrhea. Others in looking to the locality affected for a name term it entero-colitis, gastro-intestinal catarrh, etc. J. Lewis Smith says that the New York Board of Health, in their statistics of mortality for the year 1870, gave the following report :

The mortality from diarrheal affection amounted to 2789, or 33 per cent. of the total deaths. Of these deaths 95 per cent. occurred in children less than five years of age, 92 per cent. in children less than two years old, and 67 per cent. in children less than one year old." This is the history of one year in New York, and what is true in New York is true of every other city in proportion to its size and density of population.

J. Lewis Smith also says that during the five summer months there are $7\frac{1}{2}$ times as many children die from diarrhea as die from the same cause over that age.

He further says that during the five summer months of the summer of 1892 in the city of New York there were nine times as many deaths from June 1 to October 31 as occurred during the remaining seven months of that year.

The above statistics go to show how prone children under five years of age are to have this disease during the warm months of summer.

October is given as one of the months in which many fatal cases occur, although it is not a hot month. The mortality during that month and the latter part of Septem-

ber is kept up by cases that either took the disease late or the victims had stronger constitutions and did not succumb until the disease had run a long course.

In the causation of this affection two distinct factors are recognized. One is atmospheric, the other dietetic. To say that this diarrhea is produced by hot weather alone could not be substantiated, else the disease would prevail alike in country and city, and yet the absence of hot weather usually means the absence of this disease.

Looking again to Smith, we find he assigns its cause "to noxious effluvia with which the air becomes polluted during the rapid decomposition of animal and vegetable matter under the influence of a hot sun."

The unsanitary conditions which favor the outbreak of this trouble are filthy surroundings, such as slops and all refuse being thrown upon the surface of the lot or in the gutter, allowing it to find its own means of getting away, which is by evaporation and by sinking into surrounding wells, which are often shallow, poorly covered, and kept well drained by many families using from the same well during the hot dry months of summer.

By its evaporation the air becomes saturated with its foul odor, until one unaccustomed to living in such atmosphere must almost struggle for breath. In such localities we find many families crowded together in small, poorly ventilated apartments whose occupants are poorly clothed, partially fed, and scarcely ever, if ever, bathed. The exact nature of the poison contained in this foul air is not positively known, but it is generally believed to be zymotic.

Under the dietetic causes the following may be enumerated: Bad food, or feeding at irregular intervals.

Often we will find that every time the child cries the mother or nurse feeds it, with utter disregard for regularity and quantity. Sudden weaning or the substitution of cow's milk for breast milk, feeding when the child has no teeth such articles of food as bits of meat, hard fried eggs, beans,

tomatoes, oatmeal, fruits with seeds, and many other articles prepared in a way to overtax the digestive functions. A very common cause in children about two years of age is eating immature unripe fruit which has fallen from the trees in the yard, and which they eat without their mother's knowledge. There is a proverbial dread of the baby's second summer, and it is not without foundation, but if the errors cited above were avoided and the child allowed only milk for diet until its teeth are through, many cases that prove fatal would escape without any trouble.

Almost all authors describe a teething diarrhea, and attach so much importance to the fact that the child is teething that the cause is overdrawn, and when the physician is called and finds a child between the age of six and twenty months he is too apt to assign the cause to teething and look no further. I believe it an easy matter to be misled in this line of trouble as to cause. I have frequently been able in my own limited experience to trace the trouble to some impropriety in the administration of food. Teething is only a natural process of development, and should not be attended with diarrhea in a healthy child any more than entering the stage of puberty unless there has been some other morbid agent at work in the system.

We will more often find diarrhea in babies that are nursing a bottle than in any other general class. And in such cases the cause may usually be traced to the quality of food that is furnished. Among the many causes which we will find the following may be enumerated to condemn the feeding of milk from a bottle: The milk furnished by our city neighbor will come from a cow fed upon dry ground feed, dusty clover hay, and perhaps distillery products.

The cows in the city are usually taught to eat all the slop from cooking, greasy dishwater, refuse garden products, etc., and is allowed only a limited pasturage, if any at all, during the hot summer months, the remainder of the year being spent in a close foul stable, robbed of sunlight and pure air.

PUERPERAL CONVULSIONS.

BY

J. DOUGLAS MITCHELL, M. D.

THE term puerperal is now applied to all convulsions coming on during the pregnant state.

Where persons are of an epileptic nature, even in the early months of pregnancy they simulate epilepsy; otherwise, the convulsions are hysterical.

Guernsey divides causes into centric, or those which arise from direct irritation of great nerve centers, and eccentric, or those which arise from external influences, affecting nerve extremities and reflecting back upon nerve centers.

Centric causes may be physical, acting as irritants, and psychical or mental emotions.

Pregnancy may justly be termed a condition of plethora, the plethora inclining toward the head, as there is much impediment to the circulation through the great vessels of the abdomen from the pressure of the gravid uterus. Preceding and during these convulsions albumin is often present in the urine. Some authors regard this as a result of reflex irritation, while others consider both the albuminuria and the convulsions as the result of a pathological condition of the blood.

The most usual eccentric cause is the irritation of the nerves of uterus, which may be induced by pressure of presenting part, or be brought on by change of position of fetus in first stages of labor. Even the introduction of the hand into the uterus to remove adherent placenta has been known to throw a patient into convulsions, or same result may follow irritation of stomach, bladder, or bowels.

Premonitory symptoms are irritability, restlessness, heat, full, round pulse; severe pain in head frequently ushers in the most terrible case of convulsions, as it did in three of the worst cases I have ever seen.

Some cases, however, set in without warning, and cases coming on after the expulsion of the fetus you will find are the more dangerous and fatal. Regarding treatment, I merely desire to call your attention to a few remedies, most frequently indicated.

BELL.—Throbbing carotids; patient desires to go home, restless; pulse full and quick. Twitching of muscles of right side of face. Foaming at mouth, jaws tightly clenched. Pupils dilated. Convulsions often begin in right arm. Light, noise, or slightest jar of bed will often bring on an attack or aggravate one.

HYOS.—The remedy next most frequently indicated.

Patient will often complain of vertigo weeks before attack. Patient becomes wholly unconscious, eyes protrude. Pupils are either dilated or contracted, lids remain open, eyes distorted, quivering of eyelids. Great lasciviousness. Nymphomania, desires to uncover and expose nakedness, shrieks, moans. Face, a purple red. After an attack, sopor; grinding of teeth.

Some ten months ago I was called in consultation with Dr. Pollock, to see a case wherein the preceding remedies were typically indicated, and found patient going off into spasm after nap; flow had stopped. She had complained of vertigo and headache some time before confinement, but the irrepressible woman had told her, "We all have it and worse when we are 'that way,'" and she had not consulted Dr. Pollock. He gave me the information that she had an easy labor, with little flow, and when he left the woman was asleep.

Face a dark red, eyes distorted, desire to uncover, moaning and shrieking; a laughing, merry mood at times. Bell. had been previously indicated, so the doctor informed me, but symptoms had changed to hyos. Now, here we had lachesis after sleep—keynote to this remedy. Stramonium: a laughing, merry, loquacious delirium, but the weight of symptoms were with hyos., which we gave, after thoroughly

cleaning uterus with curette and irrigation, and patient gradually grew better; spasms less severe and patient soon recovered.

LACHESIS.—Spasm begins on left side and goes to right side, and then over whole body. Patient wakes from a nap to go off into a spasm. Cannot even bear gown to touch region of uterus, yet not the desire to expose as in hyoscyamus. Livid complexion, features distorted, nymphomania, lancinating pains in mammæ during pregnancy. Spits, laughs, and cries alternately.

STRAMONIUM.—Especially remedy for merry delirium. Sings and laughs. Very loquacious.

Among other valuable remedies are *nux v.*, *nux m.*, *merc. cor.*, *cuprum*, and *gels*. Much pain in occiput, or base of brain, which becomes agonizing. *Cicuta*, *secale*, *kali brom.*, *actea rac.*, like *nux*, much pain on top of head.

The bromides and opiates, in any form, I only mention to condemn, as I believe their use not only harmful, but positively dangerous.

In October of 1894 was called to see a patient out of town and found her suffering with false labor pains; under action of *kali carb.*, she was soon relieved, and the next morning I returned home. Next night was wired to come, and on my arrival found my patient, who was a large, fleshy woman, in a hard convulsion.

Pupils much dilated; a jar of bed seemed to bring on a convulsion; eyes sensitive to light, jaws clenched; she insisted constantly on going home. I began to dilate the os, which seemed nigh impossible. She soon began to throw modesty to the winds, and threw covering off. Face purple, eyes and features distorted, and I changed remedy to hyoscyamus.

Dr. J. R. Pollock was wired to come to my assistance, and as the desire to uncover and lasciviousness had almost ceased, we decided to give belladonna. All that afternoon I used dilators in shape of my fingers on the unyielding os,

and she was finally delivered of a very large child, which only lived a short time.

She rested for about one hour and my heart sank, when I was awakened with the information: "She's got another one," and I found my patient in a very violent convulsion, after which she entertained me with a song, selections from Byron, Longfellow, and other poets, with great laughter. Prescribed stramonium 30 every half hour, and after this she only had one spasm in thirty minutes, then another in one hour, and the last one she had three hours later, becoming on the next day rational, and soon became able to resume her household duties. This patient's trouble began with disturbance of the stomach and headache.

I was called to see a primipara, 15th of February, 1894, married eight months. She told me at 5.30 she felt a gush of water and went to bed. I was sent for, but did not receive call till 8.30, and on my arrival found her having convulsions.

On watching her, noticed she would awaken from a nap, and left side would begin to twitch, soon passing to right side and soon involve whole body. Sensitive to clothes bearing on abdomen. Examination per vagina revealed some flow, os rigid. I prescribed lachesis, and dilated os with Barnes' rubber-bag dilators, and soon extracted two dead fetuses about four months old, evidently having been dead several days. I thoroughly curetted, and irrigated at same time. The convulsions kept up, and I gave lachesis 200, every hour, and spasm stopped in three hours, to return no more. Patient was tender over abdomen for ten days. Belladonna was given, and she did not regain her usual health for about three months.

A few words as to curettage. As a general thing I think this is abused, but where there is a sluggish flow, or any time the placenta does not come away intact, and always in case of premature delivery, I think a gentle, yet thorough, curettage and irrigation very advantageous.

Book Reviews.

All manuscripts for publication, and all books for review, in this journal should be sent to the Publication Office, 133 William Street, New York.

A HOMEOPATHIC TEXT-BOOK OF SURGERY. Edited by CHARLES E. FISHER, M. D., Chicago, and T. L. MACDONALD, M. D., Washington. Profusely illustrated. Chicago: Medical Century, 1896.

* This imposing volume, which,—we may remark parenthetically, for convenience of reference and use—for, parenthetically again, it is a book which should be always in convenient reach,—should have been divided into two, is a standing refutation of the criticism that there are no homeopathic surgeons. It is a complete, thorough system of surgery, original in treatment, and in accord with the best teaching of to-day; and more, it is thoroughly homeopathic. A glance at the list of contributors shows twenty-five of the most successful surgeons of the day, who have been cajoled or compelled—a task of no small difficulty—into contributing thirty-five sections; each section a book of itself upon its specialty; each section being sub-divided into chapters, which in the grand total runs up in to the hundred. In addition to exercising a general supervision over the work, Dr. Fisher has contributed the sections upon Surgical Diseases, Burns and Scalds, a subject or series of subjects which are of interest to every physician. These, of course, are treated in the author's finished style, in clear-cut English, and progressively paragraphed so as to tempt the casual reader to continue to the end. The descriptive portions are full and complete, and the directions for treatment clear and most excellent. The indications for the homeopathic remedies are brief, but clear, and cover all of the most used and generally useful remedies. The space at our command does not permit us at this time to do full justice to the book, to its reliability, its practicality, its wealth of illustration, to its genuine homeopathy, for, to quote from the advertisement experts of other days, it must be seen to be appreciated. We

shall take early opportunity of referring more particularly to the sections upon gynecology and orthopedy.

A TREATISE ON THE DISEASES OF INFANCY AND CHILDHOOD.—By J. LEWIS SMITH, M. D., Clinical Professor of Diseases of Children in the Bellevue Hospital Medical College, New York. New (8th) edition, thoroughly revised and rewritten and much enlarged. Handsome octavo of 983 pages, with 273 illustrations and 4 full-page plates. Cloth, \$4.50; leather \$5.50. Lea Brothers & Co., Publishers, New York and Philadelphia, 1896.

As has been well said, Smith on children has been the familiar friend and counselor of a generation of physicians, and equally the leading text-book on its subjects for a generation of medical students; and the library which did not contain a copy was poor indeed. As the continued demand for the work has compelled the publication of the eighth edition, it bids fair to continue to guide and instruct for another generation. Thoroughly revised and largely rewritten to correspond with the changing point of view in medical art and science, it nevertheless retains the features which gave it so great popularity in the past and has not, as is the fashion of the day, subordinated all else to a cataloguing of various species of microbe and bacteria. On the contrary, the history, etiology, and clinical history of the various disease incident to children are treated in a suitable manner, being fully and clearly discussed, with an abundance of illustration and a wealth of data. In the present edition there has been added Surgical Diseases of Children, from the pen of Dr. Stephen Smith, which greatly increases the value of the work. It is typographically more than good, the type, although small, is clear and distinct, and permits of a vast amount of matter being compressed within its nine hundred pages.

OBSTETRICAL POCKET-PHANTOMS.—By DR. K. SHIBATA, Specialist in Gynecology and Obstetrics, Tokio, Japan, etc. Translated from the third edition by ADA HOWARD AUDENNID, M. D., Physician to the Children's Clinic at the Woman's Hospital. Philadelphia: P. Blakiston, Son & Co., 1895. Cloth, \$1.00.

This pocket phantom devised by Dr. Shibata to familiarize students and physicians with the various mechanisms of labor,

consists of two jointed mannikins and a pelvis, in which the mannikins can be placed so as to show the various normal and abnormal positions assumed by the fetus, so that any complications which may arise in labor may be studied and understood. In the face, brow, and vertex presentations, as well as in the abnormal positions, the body can be bent on its long axis in perfect imitation of nature. A convenient and useful little book, which will give a clearer conception of the relation of the fetal parts to the parturient canal, than many pages of description and illustration. Full instructions for the use of the phantom accompany it.

ELECTRICITY IN ELECTRO-THERAPEUTICS.—By EDWIN J. HOUSTON, Ph., D., and A. E. Kennelly, Sc. D. New York: The W. J. Johnston Co., 1896. Cloth, \$1.00.

This work treats of the application of electricity to medical and surgical practice from the most modern standpoint, in simple language, which can readily be understood by those not having a technical training.

The various subjects discussed are treated both from the theoretical and practical side; on the former, the correlation of electric and magnetic forces is considered, as well as the principles and basis of operation of the various forms of apparatus employed; while on the latter, the construction and adjustment of this apparatus are fully illustrated and described. These comprise Voltaic Cells of various kinds, Influence and Static Machines, Induction Coils, both of the Faradic and Teslaic type, Dynamos, Alternators, Transformers, Motors, Cauteries, Incandescent Lamps, etc.

The style is good, information is clearly conveyed, and the matter thoroughly up to date.

AMERICAN INSTITUTE OF HOMEOPATHY.—Transactions of the Fifty-first Session, held at Newport, June 20 to 26, 1895.

The volume for 1895, somewhat smaller, owing to judicious condensation and editing, than that for the preceding year, is not less interesting or valuable than its predecessors. The articles read at the session, and the discussions thereon, are so familiar to nearly all physicians through having appeared in the

different journalistic reports, that any remarks thereon would be merely repeating a thrice-told tale. Much credit is due the General Secretary, Dr. Eugene H. Porter, for the improvements to be noted in the make up and appearance of the book.

A REPERTORY OF HERING'S GUIDING SYMPTOMS OF OUR MATERIA MEDICA. By CALVIN B. KNERR, M. D. Price \$10.00 in sheep or half-morocco. Philadelphia: The F. A. Davis Company, 1896.

Compact, reliable, complete, and clear, this wondrous Repertory of Dr. Knerr realizes as nearly as may be possible the ideal repertory, containing a wealth of material and involving an amount of labor hard to appreciate. In spite of the amount of material contained, skillful condensing has compressed the equivalent of nearly twenty-five hundred ordinary octavo pages into a single volume which is not too bulky for convenient use. The book is handsomely printed on a thin, flexible opaque paper, having a rich effect, and which does not strain the eyes in using.

The order of arrangement or method of classification followed in the compilation, is the one inaugurated by Hahnemann, developed and perfected and used by Hering throughout his entire materia medica work, viz.: The anatomical or regional division into forty-eight chapters.

These chapters correspond to those of Hering's Guiding Symptoms, so that each chapter of the Repertory contains, therefore, all the symptoms to be found in the corresponding chapters in every proving to be found in the Guiding symptoms. Thus it practically includes all the reliable symptoms of the materia medica, and by the simplicity and clearness of its arrangement makes them easily accessible. To this end each chapter is divided into sections and rubrics sufficiently numerous to allow full scope for the analysis of the matter contained therein. This has been carefully and thoroughly done, at an expenditure of a vast amount of labor and time, which has thus been saved for the practitioner, who through the aid of the heading and sub-headings can find his way without difficulty through the thickets of endless varying symptoms. A glance at the beginning of a chapter will show the sub-headings of the subjects treated in that chapter; thus, under

13, Throat, we find Fauces, Esophagus, Palate, Pharynx, Swallowing, Throat, Tonsils, Uvula. These sub-headings are repeated in black type at the head of each rubric, then under this heading in smaller black letters are paragraphed in alphabetical order the various symptoms affecting that part. At the end of each paragraph a hand indicates cross-references, thus facilitating the finding of information sought, so that any symptom can be found in a very few minutes. A copious index refers directly to the page upon which the rubric is to be found. A modification of the Boenninghausen method of indicating the relative value of the remedies named has been adopted, adding greatly to the value of the work.

DON'TS FOR CONSUMPTIVES ; OR, THE SCIENTIFIC MANAGEMENT OF PULMONARY TUBERCULOSIS. By CHARLES WILSON INGRAHAM, M. D. Binghamton, The Call, 1896.

This is a little work for the advancement of self-study among pulmonary invalids, and the promotion of public information upon the subject of Tuberculosis. The main objects of the book are, to outline a method of general management which yielded the best results ; to indicate how the consumptive shall proceed to obtain the full benefits of the curative forces of nature ; to point out how an immunity against tubercular contagion may be maintained ; to educate the patient regarding his disease. It contains much information and advice which will be of value to those affected with, or liable to, consumption, and which if studied and followed will aid the physician in effecting a cure of the disease.

HINTS ON DOMESTIC PRACTICE AND HOME NURSING. By ANNA TEMPLE LOVERING, M. D. Boston and Providence : Otis Clapp & Son. 1896.

This little book is intended not to supersede but to assist the physician by promoting the knowledge of medical principles among the laity. In no other branch of learning is the dictum of the poet, "A little learning is a dangerous thing," so true as in matters medical. Nearly every man and every woman, is competent, in their own opinion, to advise and prescribe in a case of illness, not infrequently to the patient's injury, and it is no exag-

geration to say that were the prescribing of medicine limited to physicians only the mortality ratio would be reduced nearly one-half. However, so long as there must be amateur doctors, this book is as good if not better than most of its kind, as it is clearly written, does not contain too much, and may lead some who read it into the right way. A work upon the latter half of the subject would have great value.

PORTRAIT OF BOENNINGHAUSEN. John Arshagouni, P. O. Box 2331, New York.

This fine engraving of one of the pioneers of homeopathy is well worth a place in the office of every homeopathic physician who has turned to Boenninghausen's reportory in times of doubt as to the true remedy.

THE CARE OF THE BABY. A Manual for Mothers and Nurses. By J. P. CROZER GRIFFITHS, M. D. Philadelphia: W. B. Saunders. 1895.

This is a useful and practical book for mothers who are desirous of informing themselves with regard to caring for their children in health and sickness, and gives practical information upon the hygiene of pregnancy; the characteristics of a healthy baby, methods of bathing, dressing, and feeding of children of different ages, and general care of the child. It also gives a description of symptoms indicating disease, a *résumé* of the ordinary diseases of infancy and childhood, and directions for the treatment of various accidents. As a commendable feature we notice that treatment is generally omitted, although a long list of drugs is given with their doses and a formidable array of apparatus for the medicine closet. The medicine closet should be banished from the house, as there is, in most families, too much drugging and too much amateur prescribing.

Materia Medica.

Sepia in Leucorrhœa.—Dirty yellow spots on the face in a patient with leucorrhœa are a strong indication for sepia.

Magnesium Phosphoricum in Vaginismus.—Magnesium phosphoricum is strongly recommended in vaginismus, and pain in the vulva and vagina during pregnancy.

Helonias in Albuminuria of Pregnancy.—Dr. G. M. Christine, Hahn. Mon.—It has albuminuria as a prominent symptom, but is to be restricted in the main to those cases where the urine is clear, light-colored, and profuse.

Calcarea Carbonica Child.—Dr. Monroe.—Child has large cranium, clammy skin, cold surface, chalky, pale, and has chronic diarrhea. Fat, fair, flabby, fearful, fontanelles open, falling out of hair, flaccid skin, and flushes easily.

Magnesia Phosphoricum in Menstrual Disorders.—Under female genitals we have ovarian neuralgia, worse on right side, menstrual colic in which pain precedes the flow, with great relief from heat. Also vaginismus and membranous dysmenorrhea.

Cyclamen in Chlorosis.—Dr. C. L. Olds, Med. Adv.—No menses for a long time, the patient looks exsanguinated—as if there was no blood in her. The lips are pale, coldness of the extremities and of the prominent parts of the body.

Arnica in Accouchement.—Dr. Van den Berghe finds arnica in the 30th dil. of the utmost value in affections left behind by an accouchement. Enuresis, pains in back and limbs, and hypogastric pain before stool, are among the symptoms removed by it in the cases related.

Caulophyllum in Abortion.—Dr. L. L. Danforth.—Threatened abortion ; spasmodic bearing-down pains ; pains severe in back and loins, but uterine contractions feeble, slight flow. All

movements of child ceased ; sense of weight and profuse hemorrhage ; paroxysms of labor pain so severe, patient had to hold on to objects for support. Habitual abortion from uterine debility.

Chimaphila in Chronic Cystitis.—Dr. E. M. Hale says that he has found “chimaphila the most generally useful of all the drugs I have used. With it I have cured cases which had resisted the most vigorous internal and local treatment—cases where the muco-purulent, offensive sediment formed thirty per cent. of the whole volume of the output from the kidneys.”

Berberine in Metrorrhagia.—Dr. Brown, Med. Cent.—Berberine Sulphate.—Five grains of the 1x trituration every four hours just before and during the flow of an obstinate metrorrhagia, followed during the interval by the repeated administration of phosphorus, 6x dilution, will invariably bring about happy results. Of course this is not a specific—the similimum must always be studied.

Plumbum in Vaginismus.—Dr. Brown, Med. Cent.—Plumbum is one of the best drugs we have for vaginismus, causing, as it does, a marked hyperæsthesia of all surfaces, with a general aggravation while assuming the horizontal position. This is produced by the lead acting powerfully upon the nerve centers, producing irritation, and causing primarily increased sensibility, and later, convulsions. The patient is apt to be filled with delusions and suspicions, besides having the constipation so characteristic of plumbum.

Oleander in Crusta Lactea.—Dr. W. A. Dewey.—Oleander, twelfth, cured a case of crusta lactea in three weeks which had lasted fifteen months. It was situated behind the left ear over the left cheek, the crusts were brownish black, the odor was fetid, the hair was matted together. On removing the scabs the excoriation left was very moist. According to Lilienthal the following are the essential symptoms of oleander : eruptions on the scalp and behind the ears, with much oozing, and extending to the cheek.

Cuphea in Diarrhea in Children.—Dr. Brown, Med. Cent., says that cuphea vicosissima is, beyond all controversy, one of the

best remedies we have for the various summer complaints of children. If you have a child that is fretful and feverish; vomits curdled milk, from a hyper-acidity of the stomach; has frequent green, watery, acid stools; or even if the stools are dysenteric, with great tenesmus and colic; high fever and sleeplessness, give cuphea and cure your case. Gather the red pennyroyal plants and make the tincture yourself, according to the "American Homeopathic Pharmacopœia," class III.

Cyclamen in Menstrual Disorders.—Leipziger Populære Zeitschrift für Homeopathie.—The female, a girl or woman, is chlorotic or anæmic, with a weak stomach, disturbed digestion and distress, or even aversion to fatty foods. The colicky pains and irregularities of menstruation are almost the same as those of pulsatilla. In both there is a melancholy tendency of the mind. But the pulsatilla patient feels better in the cool and open air, while with cyclamen the contrary holds good. The thirstlessness of pulsatilla is well known; with cyclamen it is less pronounced. Characteristic is a peculiar weakness, a sensation of exhaustion, clumsiness, a dullness of both body and mind, so that a stimulant from others is necessary to exert one's self, either mentally or physically. The eyes are affected; the patient complains of spots before them, colored vision or myopia. In a girl the period will be suppressed on account of excessive dancing; in another from getting wet; in both, cyclamen will set everything aright. An unmarried lady of thirty-five, after taking cyclamen, complained of a sensation of air pouring out through her breasts; these swelled, became painful, and secreted a thin and milky fluid.

Carbolic Acid in Scarlatina.—Dr. C. E. Fisher.—Carbolic acid has rendered me most excellent service in profound blood-poisoning types, with impending or confirmed coma, intense fetor oris, general besottedness of the countenance, patient difficult to arouse, otorrhœa profuse and offensive, glandular involvement destructive. I think my attention was first called to the wide range of applicability of carbolic acid, in the fourth aqueous dilution, by an article from the pen of the late Dr. James Kitchen of Phila-

delphia, which appeared in one of our journals about ten years ago, since which time I have often found it a valuable helper. It corresponds to the putrid state of typhoid fever, the blood disorganization of yellow fever, etc. Its pathogenesis presents great prostration, unconsciousness; the heart seems almost to stop beating; disorganization of the blood; dark, almost black, and exceedingly offensive urine; face pale; mouth covered with false membrane, mucous membrane livid, corroded, exuding bloody mucus; throat red and covered with mucous exudation; skin livid, with general chilliness and coldness of the surface of the body. Surely here is presented a combination of very many symptoms characteristic of the adynamic state of scarlatina malignosa.

Calcareæ Phosphoricæ in Nymphomania.—Dr. C. L. Olds, Med. Adv.—In the female we find that there is intense sexual desire; nymphomania is produced. When she urinates it causes erection of the clitoris, intense sexual desire. This sexual desire is particularly aggravated before the menses. She has a feeling as if all the blood were surging into the parts, causing great sexual desire. In girls, the menses are apt to be too early and light-colored; in women too early and very dark and clotted. During the flow there will be labor-like pains; there may be pains shooting from the sacrum to the pubis, like sabina. After the menstrual flow ceases a leucorrhœa comes on, a leucorrhœa like white of egg and of a sweetish odor. This white of egg leucorrhœa seems to be very exhausting, like that found in the salts of natrum, kalium carbonicum, etc.

There is prolapsus of the uterus; there are fibroid growths in the uterus. During the menses there is much burning in the vagina, extending up into the chest. During lactation the menses reappear; the lochia has not much more than stopped before the menses appear. This is very prominent in *calcareæ carbonica* also. The child will refuse the breast; the milk seems to be too thin, with a saltish taste.

Spigelia in Local Paralysis.—Dr. C. H. Evans, Clin.—N. P., æt. seven years, attacked by diphtheria, had entirely recovered from the disease and was playing about the house when she be-

came faint and white and fell to the floor. I found the pulse and heart very feeble and rapid, together with other signs of paralysis of the cardiac nerves and ganglia. Heat and stimulants were freely applied and lachesis administered; beef tea of considerable strength quickly made from Armour's extract was also given in desertspoonful doses, and in course of time the patient went on to complete recovery. But within two weeks the patient was again attacked with paralysis. This time, however, the vagus, the inhibitory nerve of the heart, was involved, and the heart, like a steam engine without a governor, ran away with itself. The throbbing of the heart and pulse were exceedingly rapid, full, and bounding, the former being of sufficient force to raise the bed-clothing covering the chest of the patient with each stroke, and plainly perceptible across the room, while the number of pulsations was uncountable. Respiration was also greatly increased in frequency. *Spigelia* was now prescribed, after which gradual and steady improvement took place until recovery was fully established.

Apis in Ovarian Dropsy.—Dr. Welch, Med. Aren.—Case 3.—Cystic Ovarian Dropsy (Cure). Mrs. V., aged thirty-six, married, but without children, was expected to be confined. I was asked to examine her and see if I could tell when she would be confined. On examination I found a non-pregnant uterus, The woman was fleshy, and had been developing in size in abdomen for nine months, and was quite large, with the appearance of one pregnant at term; her circumference at the umbilicus was fifty-one inches. Her general health good, except some urinary trouble and weight and pressure in the abdomen; she had some little difficulty in breathing, with an occasional pain in the ovarian regions, mostly in the left side, which was supposed to be pressure from the fetus. Further investigation by physical examination revealed a dropsical condition, with enlargement of both ovaries. The enlargement of the abdomen was quite uniform. After making a general survey and collecting all symptoms and conditions present, my diagnosis was cystic hydrops ovarii. I prescribed *apis mel.*, 3x, three times a day; *apocy. can.*, 2x, at bedtime; also an abdominal corset belt, because of patient com-

plaining of such a heaviness and wanting to hold the abdomen up. I gave nothing but apis, and part of the time apocynum at bedtime, and in two months she was reduced in size so she could wear her former dresses with comfort. All symptoms or abdominal feeling had disappeared, and no baby in sight.

Anacardium in Puerperal Melancholia.—Dr. Hyde, N. A. Jour.—Mrs. B., æt. twenty-eight, May 3, 1894, gave birth to her first child, a girl weighing about six pounds. After her confinement, made a good recovery physically, but a depression, which came on during the last weeks of gestation, became intensified, and about this time delusions began to appear. She thought she was dead and preparations were being made for her burial, and she even heard the click of the casket. She also imagined that attempts were made to poison her. Lachesis cc. cleared these symptoms up, and then she thought that her husband was not her husband, but someone who impersonated him. She also said that everything seemed like an ugly dream, and things were so confused that she could not straighten them out. Her inability to recollect the past events troubled her greatly, and when told not to worry about what had happened, she would reply: "Oh, but I must think this out, for if I could only remember I would be all right."

She was given one prescription of anacardium 30x in water, one teaspoonful every three hours. Under this she seemed to brighten up, but at the end of two weeks began to fall back, and refused to eat. The anacardium was repeated and she gained again. This method of giving one powder in water about every two weeks was adhered to all through the case.

Gradually her delusions gave way. At first she began to think that possibly the man who came to see her might be her husband; then she commenced to recall what had happened, and finally she was sure that Mr. B. was her husband, and the occurrences of the past were all clear to her. She was discharged cured November 1, 1894, and has remained well ever since.

Cyclamen in Spamenorrhœa.—Dr. C. L. Olds, Med. Adv.—At the time of the menses, or at any time when there is uterine

trouble, the eye symptoms seem to come out in full force. It is at that time that you will find the strabismus, the dilated pupil and the obscuration of vision most prominent. This remedy furnishes an illustration of the sympathy that exists between the eyes and the sexual organs.

The menstrual periods come too early, and the blood is black and clotted, the flow is too profuse. Before the menses she is sad, melancholy, full of fears, irritable. When the flow comes on, the mental state is relieved, she feels better generally. During the flow you have pains that start in the back. They go down across the abdomen to the pubes, and then go down the thighs. These pains are violent, and while they are present the flow ceases, but on the pains ceasing the flow starts again. Again, we may find that the menses are scant, or even suppressed, and as a result of this suppression, the mental symptoms will come on; the sadness, desire to be alone, melancholy, irritability. The menses are scanty; first there will be black clots with thin blood, later, simply a scant watery flow, similar to what we see in *pulsatilla*. While she is moving about, the menses cease, but on sitting down or lying down they come on again. With these menstrual symptoms, we will have the eye symptoms that I spoke of, the head symptoms and stomach symptoms. She is very apt to have nausea and vomiting during the menses, with a left-sided headache. The head feels as if it were bound, she feels confused. The eye symptoms are < in the evening, < from going out of doors. The menstrual conditions are < from the open air, > from a close room, and although she is > from a close room, *i. e.*, a warm room, she feels as if the room were too small, she can hardly bear to sit in the room, it seems so small, and yet she is averse to going into the open air. Before the menses there is bloating of the abdomen, with great sensitiveness; after the menses there is swelling of the breasts, and perhaps the secretion of milk, and a peculiar sensation as if air were streaming through the nipples. Now, usually, if there are any breast symptoms with the menses, they will be before the menses, swelling of the breasts before the menses, > at the coming on of the menses, but with the *cyclamen* patient, this comes on after the menses.

Gynecological Etchings.

Suction of the Nipples in the Treatment of Fibrous Tumors of the Uterus.—Centralblatt für Gynäkologie.—Dr. F. Howitz relates that he happened to have at the same time under his care two women, both of whom were pregnant, and both of whom had large fibro-miomata of the uterus. One of these women nursed her child, and an examination at the end of five months after its birth showed that her tumor had entirely disappeared. The other woman did not nurse her child, and her tumor remained unchanged. These cases led him to seek if by means of suction on the nipples a favorable influence could be exerted upon fibrous tumors of the uterus. He has tried it in only five cases, the suction being carried out daily. In some of the cases there seemed to be a diminution of the size of the tumor, and in no case has any harm been noticed as the result of the procedure.

Phenomenal Premature Menstruation.—Dr. Peeples.—Mrs. W. B., a primipara, was delivered with the forceps of a girl on January 25, 1895, at noon. Five days later, or at the age of five days, January 30, 1895, at 2 P. M., the child began to menstruate, which caused much parental alarm, resulting in a second summons for me. Being absent, I failed to arrive until 6 P. M. On my arrival the nurse informed me that she had cleansed and powdered the parts well an hour previously. On examination I discovered the vaginal canal fairly well filled (in my mind) with undoubted menstrual blood, as it was traceable just as high up as I possibly could determine, without a particle of abrasion, irritation, injury, or inflammation along the vaginal canal whatever. Cessation of menstruation occurred some time during the following night. The breast and genital organs were remarkably well-developed at birth, and created some comment among those present, also vivid impressions upon my own mind.

Sea Water and Menstruation.—Dr. Houzel (Ann. de Gynec.) has published a series of statistics on menstruation in fisherwomen

on the French coast. They lead a hard life, and are ill fed. They spend a great part of the year shrimping, which involves immersion for hours in sea water, often above the waist. They walk about in their wet clothes afterward selling their shrimps. In winter they pick mussels out of rock pools at ebb tide, and return to town carrying baskets full of the mollusks, dripping over their clothes, the water sometimes freezing as it falls. All the 123 fisherwomen interrogated by Houzel insisted that the catamenia were always easier when they were actively at work at their calling. Some found that the period became painful or scanty when they led a temporarily dry life, and returned to its normal state when once more they walked in the sea to earn their bread. Puberty comes on rather earlier than in landswomen, the menopause later, and the fertility is markedly high. In short, fisherwomen are strong, and their period is maintained at a normal point more steadily than is the case with other women. Houzel, however, sees a direct relation between the immersions and the normal catamenia. He notes that lady visitors, after a few days' acclimatization, find that sea bathing is excellent for regulating the catamenia.

Surgical Advance.—Dr. Ludlam.—It seems to me that the present cry against the frequency of hysterectomy is on a parallel with that old cry that many of us remember that went up against the operations for ovarian tumors and against laparotomy. A few years ago almost all physicians were opposed to laparotomy, and ovarian tumors were allowed to go on to develop and become absolutely incurable and irremovable. So that we used to let a good many that had ovarian tumors go on to destruction that might possibly have been saved through the operation. That there are many malignant diseases that require prompt ablation of the uterine apparatus is, or should be, evident to every conscientious physician. The only great difficulty under which we now rest is the proper indication for doing the hysterectomy. Some of the conditions for which hysterectomy is now being prescribed, I believe, will go out of fashion and be forgotten. Who sees a case of vesico-vaginal fistula nowadays? Yet we all of us remember their frequency but a little while ago. How do we

account for their absence now? Perhaps, because the doctors are learning more about the use of the forceps than formerly. Because we have better obstetricians; because every student in our schools is drilled in the handling of the forceps, and taught to use them early. Now, that we have got better general practitioners, we shall not have so many cases of uterine cancers brought to us.

Fibroma of Ovary in Age.—Dr. Graëfe (Centralbl. f. Gynäk.) recently operated on two cases of this disease, which, according to Olshausen, is most frequent in young subjects. The first patient was aged fifty-four, married eight years and childless. The period continued, and there was metrorrhagia as well as profuse menstruation. The consequent anæmia and cachexia caused suspicion of cancer. On exploration, however, the uterus and cervix were found healthy; a tuberos mass, fairly movable, lay in Douglas' pouch. At the operation the mass was easily drawn up; it was a fibroma of the ovary; the pedicle was ligatured and divided without difficulty. A day or two after the operation subcutaneous emphysema occurred; the same complication followed another laparotomy a little later. The patient recovered. The second patient was aged seventy-two. Abdominal swelling had been noticed for about two years; ascites set in and caused dyspnoea. A hard, irregular tumor of the size of a man's head moved freely in the abdomen, and was clearly connected by a pedicle to the atrophied uterus. There was pain, but no discharge. The operation was easy, the pedicle readily secured, and recovery rapid. Ascites, according to Graëfe's opinion, in ovarian fibroma is due to mere irritation of the peritoneum by the hard and irregular surface of the tumor. Thus ascites was present in the second case, where the fibroma had risen into the abdominal cavity.

Gynecological Surgery.—Dr. H. Tyler Wilcox,—I would like to ask for more conservative surgery for woman, that a careful study of the neuroses which afflict woman may not be made the pretext for dissexing all women. There should be no total extirpation of the uterus. Of course we all expect to have the knife used, but often it may be deferred by a little more judicious study and handling of the case. And, of course, also it may be

deferred too long. I have seen one case in Los Angeles, which went to San Francisco, and was operated on there by one of the most excellent of operators in the allopathic school ; but she returned no better. She came under my care. I feel that she will never be a well woman again. There was only an aggravation from the treatment. When a doctor makes twenty-four operations in eight months, his work degenerates into a fad. Electricity and many other remedies should be tried first, before the total extirpation of the womb and ovaries. We do not hear of operations to unsex men. Do they not suffer disease of the testicles and other parts from gonorrheas and syphilis ? Is it not that sex who are mainly responsible for the evils which afflict women ? Yet we do not hear of the ablation and extirpation of their sexual apparatus for every headache or backache of which they may complain. We do not hear of operations for reflex conditions. I ask for information. Why is this discrimination made between the sexes ? It is a grand thought that woman, as she comes into medicine, will teach more conservatism concerning the treatment of her sex. She doesn't seek the knife, but turns her attention more to materia medica, in the hope of relieving her distressed sister with the milder means given us by the immortal Hahnemann.

Surgery vs. Medicine.—Dr. W. D. Foster.—In regard to the proposition whether surgeons remove the uterus too often or not often enough it is a question that will command itself to our consideration. I have done this operation occasionally in the last few years, and I was struck recently by a remark made to me in my town, by a trained nurse from Boston, who is a magnificent specimen of a lady. We happened to have about that time a good many cases,—all surgical cases,—to which she was called. She said to me once, "When I first came out here to Kansas City, I thought the surgeons in this country were perfect butchers. We didn't see in Boston any such cases as we have here in this hospital." I asked what was her explanation of the fact. She said in the East there are less poor doctors than there are out on the plains, West and in Kansas, where there are large tracts of country without any physician ; and there are other places where

there are poor doctors—poor, in the sense of being ill-educated, having had no advantages or experience. So these cases of uterine disease, ovarian disease in the East, in Boston, in New York, and other large Eastern cities soon fell in the hands of educated and experienced physicians, and they never or rarely get as far along toward a surgical operation as they do in the West. Possibly also the people are better acquainted with their own conditions than here, and do not permit themselves to run along as they do here and farther West, sometimes from sheer necessity. Cases come to us at a period when we cannot, dare not, operate upon them. So I undertake to say that we do not do one hysterectomy where we ought not to do it.

Bactericidal Properties of the Vaginal Secretions in the Non-pregnant.—Dr. K. Menge's (Deutsch. med. Woch.,) researches on this subject are complementary to those of Krönig on the vaginal secretion of pregnancy. Menge's first series of observations were made on 50 women who had undergone abdominal section, and who had thus been under exact observation for some time. He demonstrated the fact that in 44 out of 150 there were no pyogenic micro-organisms either at the fundus or the introitus vaginæ. He next proceeded to investigate the fate of such germs when introduced experimentally. On 35 women he made 23 experiments with bacillus pyocyaneus, 30 with staphylococcus pyogenes, and 27 with streptococcus. The result was the same in all cases; after a longer or shorter time the vagina was found to be free, and the question as to whether the vaginal secretion was acid or alkaline did not affect the result. Further investigations were made to determine the mechanism of the germicidal process, and he reached the conclusion that it depends upon several factors, which rank in order of importance as follows: (1) The antagonism between the normal bacilli of the vagina and the micro-organisms which happen to penetrate there. (2) The products of the vaginal bacilli. (3) The acidity of the vaginal secretion. (4) The properties of the secretion of the anatomical elements of the vagina. (5) Leucocytosis. (6) The absence of free oxygen from the vagina. In one of these experiments Menge found that if two similar samples of acid

vaginal secretion be taken, and one of them be sterilized by heat, the sterilized sample loses its bactericidal properties, but the other sample retains them. If by the addition of alkali the acid secretion be made alkaline its germicidal powers are lessened but not destroyed, but if the sample be then sterilized by heat it loses them entirely and becomes an excellent cultivation soil. These properties are active in the vaginal secretion of the newborn, notably so when the secretion contains no vaginal bacilli.

Total Extirpation of the Rectum.—Vanderlinden and de Buck, La Flandre Méd., claim that partial resection, or even total extirpation, of the rectum for cancer is abundantly justified where at all practicable from the point of view, both of its immediate and ultimate results. They record two successful cases of this kind. CASE I. A multipara, aged thirty-one, gave a history of a year and a half of pain in the lower belly, constipation, difficult defecation, grooved fæces. For a year glairy mucus, blood, and yellowish fetid sanious liquid had been passed with the fæces; marked loss of appetite and body weight. *Per anum* a growth was felt, ulcerated in places, extending three inches from below and invading the whole circumference of the rectum, with its greatest thickness posteriorly. The summit of the growth was easily reached, and the whole tumor could be moved downward. The operation was performed in the dorsal position with the pelvis raised and thighs strongly flexed on the abdomen. The anus was surrounded by two short incisions, which joined in front and behind. A posterior median incision was prolonged from these to the coccyx. The anal canal and rectum were dissected out as far as $1\frac{1}{4}$ inch above the growth, where section of the bowel was made. Suture of the bowel walls to the skin wound completed the operation, which lasted an hour. The patient returned home at the end of four weeks, and three months after had gained twenty-five pounds in weight, and could already retain firm stools. There has been no recurrence up to the present time. The growth proved microscopically to be a lobulated epithelioma. CASE II. C. D., aged fifty-two, married, no children. Three years' history, commencing from the climacteric, and in its details very similar to Case I. Two indurated ulcerated masses were found in the anal

region. The rectum was invaded in its whole girth by a soft, yielding, easily-bleeding tumor, whose summit was reached with difficulty four inches above the anus. Operation in left lateral position, thighs strongly flexed, and pelvis raised. The incision ran from two fingers' breadth below the posterior superior iliac spine along the groove between the gluteus maximus and sacrum toward the median line as far as the summit of the coccyx, then surrounding the anus. The musculature of the buttock was detached, the insertions of the great and small sacro-sciatic ligaments cut, and the coccyx extirpated. A part of the left side of the sacrum was removed, the abundant bleeding controlled, and the rectum isolated, commencing with the anal aperture. The peritoneum was opened after isolation of the anterior rectal wall. The bowel was cut transversely one-half inch above the growth, and its end, slightly twisted on its axis, was sutured to the borders of the skin wound. The operation lasted an hour and three-quarters, much blood being lost. A large quantity of NaCl solution was therefore injected, and, except for two days' fever, the patient did well, and at the date of report was convalescent.

Malignant Disease of the Uterus.—Dr. Pratt.—When first seen malignant disease of the uterus does not seem such a terrible thing. There may be slight ulceration and hemorrhage between the menstrual period, or an excessive flow at the menstrual epoch, and if patient is far enough along in age, it may be called the change of life. Many of these symptoms are present at the beginning of cancer. Severe pain is not always present. This accounts for the fact that so many cases are not discovered until they have reached an alarming stages of progress. Another conditions of the uterus frequently demanding total extirpation is the existence of one or more fibroids. This in a non-malignant disease. In a large majority of cases there is a chronic inflammatory condition with hypertrophy of the endometrium, which produces suffering, oftentimes makes life a burden, and severe hemorrhage may manifest itself in an excessive menstruation, or as inter-menstrual bleeding, till the patient is almost exsanguinated. In the larger tumors there is much pressure. The menopause plays a deceptive rôle in this disease, as well as in cancer. There is

accumulating evidence that the danger from uterine fibroids is much greater than was formerly supposed. There are cases of procidentia which can be cured only by removal of the uterus.

There are three methods which require special consideration—vaginal, supra-vaginal, and abdominal hysterectomy. In general, we believe that vaginal hysterectomy is the safest and most satisfactory for the cases that will admit of it. This can be done with most cases of cancer of the cervix and for all conditions where the uterus is not so large as to prevent its being easily brought down through the pelvis. There is a less liability of a return of the disease from total extirpation than from partial extirpation. This same objection can and should be raised to the method of dissecting the uterus out so as to leave the uterine arteries and, of necessity, the peritoneum and connective tissue, in which the vessel is found. The danger from leaving the whole of the broad ligament, with its covering of serous membrane and the large vessel running up through it, to anastomose with the ovarian artery, is far greater than any advantage that can be gained in making the operation. Everyone must have remarked the absence of late years of any efforts of the surgeon to consider the vessels as modifying this operation, unless it be a vessel large enough to endanger the part which it supplies with or receives the blood from. It is in this very tissue that the disease extends, and which it might have already invaded without being detected, but if left would soon show itself to the destruction of the patient, even though the operator had made claim to great skill in having removed the uterus without having tied a single vessel. By all means, when operating for malignant disease, tie the uterine and ovarian arteries, thereby cutting off the blood supply from that source, and allowing the removal of the doubtful tissue.

The abdominal is the ideal method of removing the uterus. So far, however, the mortality is greater by vaginal or supra-vaginal hysterectomy. This is possibly due to the fact that the cases are largely those that could not be operated upon in any other way, and are on the whole much more unfavorable for any operation. All operations involving the pelvic organs are more readily performed by putting the patient in the Trendelenberg position, and when the dissection has to be carried down

into the vagina the incline may be advantageously nearly at an angle of forty-five degrees. Drainage is required only where the dissection has been made in the pelvis, and can be done quite as well without extending above the united edges of the peritoneum.

Pathology and Therapeutics of Gonorrhea in Women.—A revolution in the views regarding the nature of gonorrhea has followed upon the presentation of a monograph by Dr. Wertheim at the Gynecological Congress at Bonn in 1891. Regarding this change of views, Dr. G. Klein says :

The earlier teaching of Bumm that the gonococcus could live only in cylindrical epithelium had been commonly accepted, as had been his views that purely gonorrheal peritonitis, colpitis, periurethritis, arthritis, and ovarian abscess did not exist, but that these affections were due to a mixed infection.

From year to year opposition to these views has grown. Schwarz, Pick, Fritsch and others stand for the possibility of gonorrheal infection in flat epithelium ; Fritsch, Menge, Zweifel were of the view that there is a gonorrheal peritonitis. These views, resting on clinical and microscopical observation, needed to be confirmed by bacteriological demonstration. This Wertheim supplied, pointing out the superiority of serum-agar as a medium for pure cultures, and with these cultures producing inflammation upon the peritoneum and in connective tissue. These demonstrations have proved of the greatest importance. The therapy has from these contributions not sensibly been changed. One still avoids energetic local treatment in acute gonorrhea and contents himself with guarding against new infection. Chronic gonorrhea, however, in the judgment of the majority, needs local treatment, and the dangers to the subject may be such as to demand operative interference. With the increased danger that gonorrhea is now known to entail, prophylaxis has received greater attention.

The recent work upon the subject may be briefly reviewed :

1. *Ætiology* : The German investigators agree without exception that the gonococcus of Neisser is the exciting cause of gonorrhea. In France there are a few, grouped about Eraud, who deem the "staphylo-diplococque urethral" the cause.

2. Methods of staining gonococci. The great number of methods recommended for staining shows that at the best there is no characteristic response to staining.

3. Culture growing. The method of Wertheim for securing pure culture of the gonococci upon serum-agar has proved of the greatest importance. In the question of the infectiousness of chronic gonorrhea, Steinschneider has shown that cultures from a chronic gonorrhea behave exactly as do those from an acute case. Finger has claimed that the gonococci are quickly destroyed by an elevation of temperature, and that gonorrhea for that reason is cured by intercurrent acute diseases. On the contrary, Wertheim has demonstrated that the gonococci continue to live at 45° C. (113° F.).

4. Diagnosis. The typical diplococci, situated within the cell and responding to Gram's method of staining, permit the microscopical test.

5. Distribution of the gonococcus.

Bumm and others have admitted that the gonococcus may be observed in cylindrical-epithelial cells and in certain very delicate flat-epithelial cells. Wertheim has demonstrated the gonococci in the flat-epithelial cells of the peritoneum, in the connective tissue of the fallopian tubes, in the lymph spaces themselves and in ovarian abscesses. The penetration of the gonococci into tough, laminated flat-epithelium has not been demonstrated.

6. Spreading of infection. This has been shown to be possible through continuity of surface, through lymph spaces and through the blood.

The Question of Puerperal Self-Infection.—Dr. Charles Jewett.—Even in healthy women who have not been examined the vaginal mucus frequently contains pathogenic bacteria. To what extent these vaginal germs are liable to become virulent is a question still in dispute.

Of sixteen obstetric authorities consulted, in this country and in Europe, more than half practice vaginal douching at the beginning of labor, and are presumably believers in auto-infection. Their puerperal results, when compared with those of their colleagues who do not douche, proved practically nothing for the douche.

The statistics of Leopold, in parallel series of cases with and without the douche, are more conclusive. They establish the fact that preliminary vaginal irrigation is not only unnecessary, but injurious.

Leucorrhœal secretions expose the woman to puerperal infection. Several instances of post-partum fever from the latter cause are cited from the author's experience. Of sixteen gonorrheal women eight had feverless childbeds ; in eight the puerperal temperature exceeded 100° , and in some instances reaching 103° F. One death occurred in a case seen in consultation, in which an ichorous vaginal discharge, existing before labor, was believed to have been the source of infection.

In fifty-three examinations made by Dr. Jewett, the litmus reaction was not always found a reliable test of the condition of the vaginal secretion. It was sometimes strongly acid in pathological secretions.

The paper concludes with the following recapitulation :

There is no clinical proof that puerperal infection can occur from normal vaginal secretions.

All childbed infection in women previously healthy is by contact.

Prophylactic vaginal disinfection as a routine measure is unnecessary, and even in skilled hands is probably injurious.

Its general adoption in private practice could scarcely fail to be mischievous.

In healthy puerperæ, delivered aseptically, post-partum douching is also contra-indicated.

These rules must hold good in the simpler cases of manual or instrumental interference, in which the uterus is not invaded.

A purulent vaginal secretion exposes the woman to puerperal infection.

In the presence of such discharges at the beginning of labor, the vagina should be rendered as nearly sterile as possible.

Concentrated antiseptic solutions should not be used, and the process should be conducted with least possible injury to the mucous surfaces.

In case of highly infectious secretions, the preliminary disinfection should be followed by douching at intervals of two or three hours during the labor.

Sterilized glycerine or other suitable material may be used to restore the proper lubrication of the birth canal.

The safest and most efficient means for correcting vicious secretions is a mild antiseptic douche repeated once or more daily for several days during the last weeks of pregnancy.

It is the duty of the obstetrician to know before labor the amount and character of the vaginal discharge.

Clinically, the amount of the secretion, its gross appearance, and the condition of the vaginal mucous membrane, and of the adjacent cutaneous surfaces, are a sufficient guide to the treatment.

Possibly unclean contact within twenty-four to forty-eight hours before labor is an indication for vaginal disinfection.

Obstetrics.

The Causation of Face Presentations.—Dr. Muggia, in an exhaustive monograph, discusses the various alleged etiological factors in face cases, and gives in a tabular form the details of 41 such labors. The frequency with which these confinements occurred was once in 137 cases (41 in 5644 labors), and of the 41 instances met with, in 25 the chin of the child was to the back and right side, in 2 it was to the front and right, and in 5 it lay transversely and to the left. Among the fetal causes for the presentation found by Muggia were fetal struma, coiling of the cord round the neck, dolicocephaly, absence of the cranial vault, small size of the fetus, oblique position of the fetus, maceration; increase in the biparietal diameter, abnormal size of the head, abnormal shortness of the neck, and the female sex. The maternal causes included repeated pregnancy, hydramnis, uterine obliquity, uterine tumors, low implantation of the placenta, and pelvic contraction. In addition to the causes given in this already long list, the author adds those that have been advanced by other writers, but which he has been unable to confirm. It would seem that the fetal causes are the more important, and heredity may even come

into play. A practical conclusion is that, if a face case evidently represents the expression of given anatomical conditions, maternal and fetal, the intervention of the obstetrician is in the great majority of cases unnecessary. The genu-pectoral position of the patient in labor is advisable in order to aid the rotation of the chin. All external and internal manual interference should be undertaken only in definitely ascertained cases and under certain circumstances, for the fetus which presents by the face will often come safer thus into the world than if its presentation is modified. In only one of the author's cases was an asphyxiated infant not resuscitated. Of course, it would be absurd to say that a face case is more favorable than a vertex; at the same time, in the circumstances, presentation by the face may be a natural way of escape.

The Diagnosis of Pregnancy.—Dr. Noble, Polyclinic.—It is a current belief in the profession, which is supported by the authority of obstetrical text-books, that the diagnosis of pregnancy during the first three months is difficult or impossible. In my judgment, a practitioner skillful in making the bi-manual examination will be able, ninety-nine times out of a hundred, in cases of suspected pregnancy, between the sixth and twelfth weeks, to definitely determine whether or not pregnancy exists.

The sign known as the sign of Hegar is a thoroughly reliable evidence of pregnancy. The shape of the unimpregnated uterus is pyriform, flattened from before backward. When the cavity of the womb is occupied by a growing ovum, certain changes in the form of the womb and in its structural peculiarities rapidly ensue. As is well known, the corpus and fundus of the womb develop with great rapidity, in order to make room for the growing ovum, while, on the other hand, the cervix grows slowly, and even toward the end of pregnancy its size has not greatly augmented. Within six weeks after the beginning of pregnancy the ovum has grown sufficiently to cause the corpus and fundus of the womb to assume a distinctly spheroidal shape. As during this time the cervix has altered very little in its form, we have present, to make use of geometrical terms, a spheroidal body posed upon a cylinder of the sphere jutting out from the cylinder prominently and in

every direction. In other words, when examining the pregnant uterus, between the sixth and twelfth weeks, the uterus will be found enlarged to correspond with the period of pregnancy, the corpus and fundus will be found as a spheroidal body, and the corpus can be easily made out as jutting boldly out from the cervix in front, behind, and at each side. In my experience this sign is of the utmost value and absolutely reliable. The spheroidal body of the womb will be found softened, and as it is held between the two hands in bi-manual examination, a feeling of semi-fluctuation can easily be made out. This softening and semi-fluctuating feel should be found in all cases.

What conditions could be confounded with pregnancy, by giving rise to the same or similar signs as those described? These, I think, are practically two. 1. Hematometra, due to an imperforate cervix. The practical man will realize that this condition will seldom embarrass him in making a diagnosis of pregnancy, as the average practitioner meets with it not more than once in a lifetime. Moreover, the history of the case would put him on his guard with reference to it, as hematometra occurs either as the result of a congenital defect, and is then found in young girls about the age of puberty, whose history is sufficiently characteristic to at least make the practitioner watchful; or it occurs later in life as the result of atresia of the cervical canal, brought about by inflammatory conditions of a destructive nature. These cases are likewise very rare, and their history is quite suggestive. 2. Certain cases of intramural fibroid tumor, in which, owing to pelvic congestion, the walls of the uterus become quite soft. But here also, the conditions are not typical. The uterus is not uniformly enlarged, it projects perhaps anteriorly and not posteriorly, the semi-fluctuating feel cannot be made out, or some other evidence is present, to make the examiner aware that he is not dealing with pregnancy.

It is well to say a word about conditions which prevent the examiner from making out this characteristic sign of pregnancy. It will be readily seen that if pregnancy occurs in a womb which already contains a fibroid tumor, that the sign is not available. This is equally true when the pregnant uterus is jammed in between tumors of the ovary. Extreme development of adipose

tissue may prevent its recognition, on the one hand by making the abdominal hand unavailable, or on the other by preventing the examining finger from reaching high enough up, *per vaginam*, to make out the form and consistency of the uterus. It will occasionally happen also that pregnancy takes place in a womb bound down by adhesions, in a pelvis in which the structures are distorted as the result of former inflammatory processes. In such cases the development of the pregnant womb is frequently atypical. All the conditions described have been encountered, and my remarks concerning them are based upon experience. In such cases the examiner usually finds enough to awaken his suspicions, but not enough to form a positive diagnosis, and thus is obliged to reserve his opinion.

Certain other corroborative evidences of pregnancy are very valuable during this period. The violet discoloration of the vagina, most marked beneath the urethra, frequently appears as early as the sixth week, and is usually well developed as early as the third month. To an experienced observer, who has been accustomed to note the difference between the slight blueness due to pelvic congestion, and the intense discoloration which is present in pregnancy, owing to the changes in pelvic circulation, this sign is of great value.

Evidences of pelvic congestion, such as velvety softness of the vaginal walls, marked pulsation in the vaginal and uterine arteries, unassociated with inflammatory conditions, have a definite corroborative value.

Softening of the cervix has a certain but very slight importance, by no means commensurate with the stress usually placed upon it. The cervix often becomes soft and pulpy as the result of pelvic congestion unassociated with pregnancy; and, on the other hand, a cervix which is the seat of cicatricial or chronic hyperplastic changes will not become softened until the latter months of pregnancy.

About the fourth month the pregnant womb rises out of the pelvis. It is evident that when this takes place the valuable sign discussed, is no longer available. At this time and until the fetal heart sounds can be heard, the sign of Hegar, namely, the extreme softening of the lower segment of the uterus as contrasted

with the firm cervix, is of the greatest value. These two signs, it will be seen, are complementary to each other. The sign discussed in this paper is of value prior to the ascent of the womb from the pelvic cavity, the sign of Hegar from that time until the fetal heart can be heard.

Twin Pregnancies.—W. O. Clark, M. D.—In my thirteen years, nearly, of practice, with a record of 270 obstetrical cases, I have no experience to relate with multiple births greater than twins, and but three cases of these.

CASE I. was a farmer's wife, age thirty-four, sixth pregnancy. The first child, an 8½ pound girl, was born in a normal manner, after about five hours of labor. Following the expulsion of this child, the pains very soon became severe again, and, instead of expulsion of the placenta, I discovered the arm of a second child presenting. I at once pushed back the arm, and tried every method within my power to bring about a position whereby the child could be delivered. The pains continued extremely strong, and almost incessant, and after working for several hours, and until I was almost as much exhausted as the patient, I sent for the nearest counsel, who was an allopath, but a man of many more years experience than myself, and one of considerable reputation in obstetrical manipulations.

He, too, labored indefinitely to effect version in some form, but without avail; and finally being convinced of the death of the child, we removed the arm with Smellie's Perforator, when the head was brought into position, and the delivery of a large male child was soon effected.

The mother's recovery was rapid and complete.

CASE II. was the sixth pregnancy, mother's age thirty. Normal and uneventful births.

CASE III. was of considerable interest, December 4, 1891, I was called to a patient new and strange to me. A short, stout, robust German girl, age twenty, married, just past eight months pregnant. She stated that she had called me to relieve her head, as for several days she had been suffering from a "splitting" headache. Pain seemed all over the head, especially about the base of the brain. Face quite flushed; band-like feeling about the

head ; blind from pain. I found history of an abundance of urine passed, but on examination of a specimen later at my office I found a large percentage of albumen.

I prescribed gelsemium, and left the house trembling with anxiety, both for the patient and myself, as I felt certain we would see convulsions before the termination of pregnancy.

I hadn't long to wait. Early next morning, as I was dressing, a ring came at my bell, and a summons to hasten to see Mrs. H., "as she was in a fit." As I entered her room I found her sitting up in bed, face injected, eyes protruding, mouth bleeding from a bitten tongue, and she in a dazed, confused state of mind, wondering "what had happened." I had only time to note her pulse when a second spasm seized her. I examined as to labor, and found the os soft and yielding, but little dilated, and no signs of pains.

To delay delivery, I was sure, was death to the woman, so hastening the husband, the only person present, for another physician, I cared for the case and made arrangements, if my counsel coincided, for immediate delivery. A third spasm attacked her during this interval, but before a fourth could come on my assistance had arrived, and we had her well under the influence of chloroform.

In two hours we had the os dilated, applied the forceps, and effected the delivery of twin girls, one of nine pounds', one of $7\frac{1}{2}$ pounds' weight.

The mother had no return of the convulsions ; and although she suffered for two weeks from headaches, and her memory was defective for a month or more, she gradually made a complete recovery.

Perineal Lacerations.—Annie Lowe Geddes, M. D. —I repair at once and have not yet seen any unfavorable results ; no "pocketing" nor any case that failed of perfect union. During labor I do not "spend my time in washing and disinfecting the instruments necessary for repairs," but I employ myself with measures to prevent the necessity for their use ; in any event a pocket case of instruments is sufficient and a display of these unnecessary ; They should be washed and disinfected immediately *after* using,

not *before*. A leg-brace is an abomination and should not be produced in the obstetrical chamber. If repairing is conducted promptly no anæsthetic will be required, certainly not cocaine, under the extremely susceptible condition of the recently delivered woman.

An Illinois physician urges the early use of the forceps with an earnestness bordering on hysteria. His lurid picture of obstetrical operations during the "Dark Ages" is real creepy. How vivid his picture of the "shallow obstetrician imploring his patient to martyr herself." One sees the poor doctor reduced to tears and wringing his hands in his earnestness—while that same "confiding patient suffers useless and ineffectual agony hour after hour." What kind of a homeopathist is he if his patient suffers, "hour after hour uselessly"? Probably of the rank of nominal homeopaths who administer opiates to suffering patients and, when reproved for unhomeopathic practice, retort in an aggrieved manner, "Well, what would you do; would you let your patient suffer?" It, evidently, has never entered into their scheme of therapeutics to study their homeopathic materia medica! Then with what fine scorn our advocate of the forceps annihilates the "impudent and foolish pretenders" who refuse to be guided by the "demands of intelligent women for forceps delivery, when labor is needlessly prolonged." Surely, surely! We will be guided by our intelligent patients! Why not?

Sometimes the patient would seem to possess all the intelligence manifested when the knight of the forceps is abroad in the land. Again, how our orator's indignation spends itself upon the conscienceless medical man, whom he graphically describes in the engaging pastime of "holding an innocent victim over the brink of the grave." Bad man! After our harrowed feelings are somewhat soothed by the sweet picture of a speedy delivery effected by the writer's mechanical skill and "gentle words," he proceeds with the charge that all non-advocates of the forceps are unskilled in their use. I say emphatically that this is not the case, and I assert further, that physicians having the best interest of their patients at heart will never advise the general use of the obstetrical forceps, even though, so far as the attending physician is concerned, they are a "time-saving invention."

Pediatrics.

Tic de Salaam.—Under the name of tic de salaam, Dr. J. Collins, Pedr., describes a convulsive form of disease but little known and rarely described in this country. It is a form of epilepsy observed almost exclusively in first infancy. Text-books of pediatrics in the English language contain no reference to it, either under this name or any other.

In the forms usually observed, the disease is made up of a series of rapid, oscillating movements of the head and superior part of the body (spasmus salutaris), which occur with a rapidity varying from ten to thirty times per minute. In some instances, during the height of the attack, the upper extremities are shot into the air, and for the moment remained fixed, while the eyeballs are rolled up, and the face has a fixed, non-expressive appearance. Whether or not consciousness is entirely lost during this period cannot be said with certainty—first of all, because of the tender age of the patient, and secondly, because the rapid, fluctuating movements prevent the patient from answering or communicating. In marked contrast to the ordinary epileptic convulsions, whether they be of the “petit mal” or “grand mal” form, is the absence of any warning, and the rapidity with which the little sufferer regains his composure after an attack—that is, there seems to be none of the customary drowsiness, stupidity, and desire to be left severely alone, as after an attack of epilepsy. Apparently there is no tendency to failure of mental development, or loss of what psychical faculties the child may have already obtained. The number of attacks which the patient may have in twenty-four hours varies from a dozen up to fifty or sixty, each attack lasting from one to three or four minutes. The phenomena have all the characteristics of a motor explosion or liberation of energy. Their occurrence is brusque, a rapid cessation between each twitch, and an abrupt departure. The consensus of opinion of those who have seen most of this condition is that the disease is a modification of the “haut mal.”

Fatal Case of Uncomplicated Chicken Pox.—Dr. W. B. Nisbet, Aust. Med. Jour.—It appears to be a generally accepted fact that varicella is such a trivial disease that no treatment is required, and, as complications are extremely rare, no precautions are necessary to prevent their occurring. West writes, says the author, "The disease is one so void of danger that it hardly requires any treatment"; while Collie, in Quain's "Dictionary of Medicine," says, "No physician has recorded a fatal case of chicken pox." For this reason, says Mr. Nisbet, the following case is recorded, which might otherwise seem too trivial to be worthy of note: A healthy baby girl of eight months showed signs of the eruption of the chicken pox, September, 1894. Four older children in the house also had it, and an epidemic of the disease was running through the town at the time, so the diagnosis was a matter of no difficulty. For the first three days the case progressed in the ordinary way, the rash being by no means copious and the constitutional disturbance unimportant. But on the fourth day a new crop of vesicles made their appearance, and were so numerous that by the sixth day every part of the child's body was covered, even the soles of the feet and the palms of the hands. The eruption showed no tendency to become confluent, except over the back, which was constantly rubbed by the restless movements of the child. On the seventh day numerous spots appeared on the tongue, on the hard and soft palate, and on the inside of the cheeks; these changed to irritable ulcers on the ninth day, causing great distress, and on the morning of the tenth day the child died, without any other complication making its appearance. The temperature remained at or about 102° F. during the illness, only once, on the evening of the fifth day, reaching 103° . It fell to 98.8° on the ninth day and remained normal up to the time of death.

Mr. Nisbet thinks that death was owing to the immense area of skin involved, in the same way as a very extensive burn causes death from shock in a child. The exhaustion evidently was so great that at the crisis of the disease, when the temperature fell to normal, no amount of artificial stimulation could avert the fatal issue.

Infantile Convulsions.—Dr. Chernbach (Rev. Mens. des de l'Enfant Mal.) reaches the following conclusions :

1. The urine of convulsive affections, filtered and introduced into rabbits by intravenous injection, produced clonic and tonic convulsive movements.

2. These convulsions appear more quickly and with greater violence than those produced by normal urine.

3. Prolonged boiling partially diminishes the urinary toxicity by modifying the contained toxins.

4. The presence of convulsive substances in the urine during convulsive affections appears to be established.

5. Bromide of potash, included in the treatment of the patients and injected into animals in the urine which contains it, diminishes or even suppresses the intensity of the convulsions.

6. In the convulsive affections of children the urine has shown an earlier and more energetic convulsive action than that of adults under the same conditions. We know that certain apparently insignificant affections can at times lead in small children to fatal attacks of eclampsia. Two cases are cited where the existence of a fatty liver led the author to ascribe the fatal issue of the convulsions to the condition of the liver. It is probable that in all these cases, the liver, not being in normal condition, cannot sufficiently influence the toxins which pass through in the blood from the intestines, and so convulsions are produced.

Conclusions : 1. One can admit as probable the fact that convulsive substances are present in the organism producing auto-infections.

2. These auto-intoxications in all probability, according to results obtained, offer the best explanation of the production of convulsive phenomena in children during the infectious diseases and their sequelæ.

3. The changes in the liver, by diminishing its antitoxic action, favor auto-intoxication and consequently the occurrence of convulsions.

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EDITOR, B. F. UNDERWOOD, M. D.,
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RECENT ADVANCES IN OBSTETRICS.

BY

T. GRISWOLD COMSTOCK, M. D.

THE art of obstetrics is the oldest in the practice of medicine, and as a science occupies a high rank, improving as experience increases with years. It is to be lamented that for the past thirty years our profession has seemed to study and cultivate gynecology with more enthusiasm than obstetrics.

In the dark ages, even four hundred years ago, obstetrics was practiced by females, and the celebrated physician, Bartholini, about 1640, said of the art and science of obstetrics the following words: "Obstetricam artem nec exercui, nec exercere volo." "I have neither practiced the obstetrical art, nor do I wish to do so."

As late as 1522, Dr. Wert in Hamburg disguised himself as a woman to attend and study a case of labor. He was detected, and for his presumption was burned alive.

How changed now ! To be a skilled and expert obstetrict is a great accomplishment, and such a practitioner can well appreciate the words of Tupper, when he said :

“ Come to the mother when she feels,
For the first time her firstborn's breath,” etc.

Where is the accoucheur who has not witnessed the intense feelings of a young parturient, who for the first time has just looked upon her babe, and realizes that she is a mother ?

When we studied medicine it was the unwritten law that it was necessary to be a skillful and experienced obstetrician before we could practice gynecology ; as likewise a good physician before we could aspire to become a good surgeon.

It is well known that much of the practice of the gynecologist is the direct result of accidents and ailments originating in the confinement room. This being granted, if we as “ healers ” of the sick are imbued with real love and enthusiasm for the good that we can do in our profession, we should not fail to make ourselves masters of the obstetrical art, before presuming to practice either surgery or gynecology.

Labor is a natural process, and we concede that many cases would do much better when left to nature than treated by “ meddling midwifery.” Notwithstanding this, we find in practice a sufficient number of abnormal cases to require the obstetrician to be thoroughly instructed in clinical practice, so as to be ready to meet any emergencies, and wherever required to act promptly in giving the patient such instrumental assistance as may be necessary to bring to a safe termination any abnormal or protracted labor. Let us recall the facts of the parturition of the Princess Charlotte of Wales, in 1817. Her court physicians treated her in accordance with the practice which at that date was approved of by the highest

obstetrical authority in England. In the case of the princess, the waters broke fifty-two hours before her delivery. She seemed to have died from exhaustion, the sequel of a lingering labor, and the autopsy showed that the uterus contained over twelve ounces of blood, proving the existence of complete uterine inertia. It was a dread of instruments that kept her attending accoucheurs from applying the forceps, and terminating early what proved to be a protracted and exhausting labor. At that date the watchword of the British profession was: "Meddlesome midwifery is bad midwifery!" If the forceps had been used the life of a most amiable princess and heir to the crown of Great Britain might have been saved.

The few words of this paper are intended to be suggestive, and I shall only touch upon the recent advances and changes in obstetrics that have been discussed in medical journals during the past year.

STATISTICS OF THE MORTALITY OF CONFINEMENTS IN MATERNITIES AS COMPARED WITH THOSE IN PRIVATE PRACTICE.

It has been found in private practice that the mortality of women in labor is twice as great as it is in well-regulated maternities. This being statistically proved is a matter of interest, and therefore the obstetrict in private practice should change his plan of treatment accordingly, so that he may show as good results as hospitals claim. The cause of this difference is that in modern lying-in establishments strict asepsis is the rule, so that the accoucheur is assured that the puerperal patient will go through her period of confinement in an apartment absolutely free from any heterogenous influences that might expose her to infection. Unfortunately in country obstetrical practice—occasionally in cities—practitioners have not yet learned the significance and the detail of thorough asepsis in the confinement room. The principle of asepsis in surgical opera-

tions is now recognized by all well-educated physicians, and it is quite as requisite in the confinement room as in surgical wards. Unfortunately, in the country, where trained nurses are not to be had, it is difficult to practically carry out absolute asepsis. By the way, people are beginning to appreciate these facts, and we find some of our best and wealthiest patients, when attacked by a serious illness, suggesting to us that they would prefer going to the hospital, because they realize that they will not only get better attention there than it is possible to secure in private, but that they will occupy an apartment absolutely aseptic. In obstetrical practice the more perfectly aseptic we can keep our patients, the lower will be the rate of mortality.

THE PERINEUM AND METHOD FOR PREVENTING ITS RUPTURE.—EPISIOTOMY.

The rules for the prevention of rupture of the perineum I need not mention, because they are well known to every good accoucheur; but it is necessary in certain cases in order to save a greatly distended perineum to resort to the operation of episiotomy, which was first recommended by Sir Fielding Ould, the English "man-midwife," as he was named, in 1742. This operation, I am well aware, is neither known nor practiced by many obstetrists, but it is of such practical importance that I cannot pass it by. It is now advocated by the best authorities in our country, and more especially in Austria and Germany it has been in use for the past fifty years. There was a time when it was scarcely mentioned in any American text-book, but at present this is quite changed. It was once described and facetiously denominated as the "young practitioner's operation," but now it is recommended by such authorities as Leavitt, Parvin, Hirst, Lusk, Winckel, Carl Braun, and the new "American Text-book of Obstetrics." Its success in preventing a traumatic laceration by lateral incisions made in

the vaginal ring, depends upon timing the operation so as to anticipate the tearing of the perineum posteriorly into the rectum. The incisions are made laterally into the vaginal girdle, already distended to its utmost capacity, when, by either a blunt tenotomy knife or scissors, incisions are made at a point about one-third way from the posterior to the anterior commissure, at the moment the parts are most upon the stretch. The cuts extend inward for about one inch, and this relieves the great tension of the vaginal ring, and the child's head will soon be delivered. When the delivery has been accomplished, and the woman is quiet, these artificial incisions, if sutured with catgut, will heal by first intention, and are much easier to manage than an antero-posterior laceration, such as would have occurred unless these lateral incisions had been made.

PRIMARY OPERATION FOR LACERATED PERINEUM.

After every delivery, before the accoucheur leaves his patient, the perineum should be ocularly inspected, internally as well as externally, and if any considerable rent is found, it should be immediately repaired. This practice now almost goes for the saying, as it is the consensus of the best authors and experts in the profession, and no medical man should presume to attend a case of labor without having in his obstetrical bag the instruments and sutures necessary for the repair of a torn perineum.

LACERATIONS OF THE CERVIX.

Slight lacerations of the cervix occur often, especially in first labors, and are usually situated upon the left side, corresponding with the first position of the head,—vertex left. They may be left to nature, as they are regarded by some authors—Parvin—as “physiological.” When, however, the tear extends up to the vaginal junction, and a serious hemorrhage is the result, the rupture may require to be sutured to stop the bleeding. This can be easily done, and

silkworm gut is the preferable suture. In such a case to stanch the hemorrhage, the operation is quite as necessary as the primary repair of a ruptured perineum.

The forceps, now universally esteemed as an instrument for shortening the pains of a lying-in woman, by delivering the child with absolute safety and terminating a tedious labor, are now resorted to much more frequently than in former years. To sum up the indications for them, we may say that whenever during the progress of any labor the mother or child is exposed to danger from delay in the delivery, and the forceps can be applied and thereby the delivery hastened and danger averted, they are indicated and should be applied without delay.

PUERPERAL FEVER, SEPTIC INFECTION, SEPTICÆMIA.

The name puerperal fever is now almost discarded by some of our colleagues, they arguing that it gives an incorrect conception of its true pathology. No less an authority than Dr. Robert Barnes of London, says: "Puerperal fevers are fevers in a puerpera, and we may abandon the vain attempt to find one definite puerperal fever, but recognize the fact that *there are puerperal fevers!*" In other words, Dr. Barnes admits that puerperal fevers may come from causes autogenetic, as well as heterogenetic. Although puerperal fevers are usually from heterogenetic causes,—infection foreign to the patient herself or from local origin,—yet from clinical experience we are convinced that an essential fever may happen to a puerpera, and her attack may come from emotional disturbances, shocks, puerperal neuritis, and other causes quite unknown. All cases of fever after labor, manifested by hyper-pyretic temperature, bounding pulse, purulent and offensive lochial discharges, giving any suspicion of infection, should be regarded by the accoucheur as grave; because such symptoms are presumptively diagnostic of a septic condition of the endometrium. With such symptoms to prescribe for (in

addition to our properly selected homeopathic remedies), local treatment should be employed and addressed to the uterine cavity. If there has not been a complete and clean delivery, and we have reason to fear that pieces of the placenta remain behind, curettage of the uterus will be necessary.

This should be done with Rheinstaedter's irrigating curette, and with strict anti-septic precautions, using either lysol solution, $\frac{1}{2}$ to 1 per cent. sublimate, 1-4000, or sterilized water, as the practitioner may prefer. During the past year the curette seems to have gained increased confidence among obstetricians, and the advantages of the rinsing curette of Rheinstaedter we can personally recommend, after having frequently employed it in clinical practice for the past three years.

"*Gonorrheal Labor*" has been mentioned in the obstetrical journals during the past year, and sad to say, its existence is conceded. Some years since I read a paper before the Institute, in which I spoke of *gonorrheal puerperal fever* as the consequence of gonorrhea located within the endometrium and extended to the fallopian tubes, occasioning salpingitis.

PUERPERAL SEPSIS.

In grave cases of acute septic puerperal peritonitis, with exudations and suppuration within the peritoneal cavity, it has been proposed not to miss the opportunity of relieving this serious condition by neglecting abdominal incision, laparotomy, and cleansing the cavity by flushing it with sterilized hot water, and then to keep up free drainage. This surgical procedure has saved many a woman from a speedy and painful death.

OPHTHALIMIA NEONATORUM.

Gonorrheal Infection contracted during gestation is liable to cause another serious trouble, nothing less than ophthal-

mia to the newborn child. The therapeutics of this affection have heretofore been the modified Credé's method of treatment, and when carefully carried out was usually successful. But it has been very sensibly proposed to institute prophylactic measures before the birth of the child, to do away with this Credé plan of curing the tender infant's eyes, by not waiting until the mischief has been done.

One celebrated surgeon remarks that he "sees no reason why we should not prepare the vagina and cervix for a clean and non-contaminating delivery of a child first, thoroughly and completely, as for an abdominal section, or for plastic operations upon the bladder, cervix, or perineum." This is a practical suggestion, and by treating the vaginal infection antiseptically before the labor, it may be possible to absolutely stamp out the dangerous ophthalmia of the newborn. It has been estimated that if we can do this successfully, we can reduce the number of asylums for the blind from three to one. This is an appeal to the attention of every practitioner of obstetrics, as it has been found by statistics that twenty-five per cent. of all cases of blindness are caused by ophthalmia of the newborn.

We cannot pass this by without advising that with all of our precautions for treating gonorrheal infection, it is without exception our duty to examine the eyes of every newborn child, and if we find anything about them that looks suspicious, they should be bathed with pure water, and a ten per cent. solution of boric acid should be instilled into each eye, several times a day, until the eyes are clear.

ABORTION.

Cases of abortion are of such frequent occurrence that the young practitioner should be well instructed in their management. In large cities we often meet with instances of what is known as "criminal abortion," and not unfrequently we may have, in family practice, cases of habitual

and recurrent abortion caused by the existence of latent constitutional syphilis in one of the parents. In the management of abortion we must observe absolute asepsis, or if the abortion is incomplete, we must direct our therapeutical resources to remove all that has been left behind of the membranes; and in septic abortions, with infected maternal membranes, if we cannot remove with our finger the contents left in the uterus, we must resort to curettage and irrigation.

We have not named the homeopathic medicines for septic conditions, because they will be indicated by the special symptoms that confront us in each case. I, however, wish to mention one remedy possibly not known to the profession generally, but which has proved valuable, and may be recommended as a prophylactic in habitual abortion. The remedy is *asafetida*, and is to be given in the first attenuation, or in triturated tablets of one to two grains, three or four times daily, selecting the period of the pregnancy at which the patient had her last miscarriage for their administration. Lastly, we can almost in two words give the treatment of a real abortion that cannot be prevented or averted—and that is to see that the uterus is emptied.

MASTITIS.

The essential cause of inflammation of the breasts, and of sore and cracked nipples, is now frequently recognized as sepsis. It has been observed that this trouble seems to happen to a mother whose child has either ophthalmia, thrush, or ulcerative sloughing of the cord at its insertion. It may also come from an unclean nurse, and for this reason no other than a trained nurse should be tolerated in the confinement room. If the nipples are at all affected by ulceration, they should be irrigated, before nursing, with a ten per cent. solution of boric acid, and after nursing, with a mercurio-iodide solution, 1-100. When they are fissured, a little tannic acid should be dusted upon them, or

they may be painted with tincture of benzoin. Occasionally the fissures may require to be touched with a fine point of lapis infernalis.

Albuminuria and its serious nature has been frequently commented upon during the past year. Here, again, "prevention is far better than cure." If, among our patients, a young lady has suffered from albuminuria so that we fear Bright's disease, and our professional opinion is asked about her marriage, we should unhesitatingly advise against it. During pregnancy albuminuria is a serious matter, because of the threatening danger of uræmia and eclampsia. If, with the albumin, hyaline casts are found in the urine, the patient's condition is one to be regarded as serious, and cannot fail to worry the medical attendant until delivery has been safely completed. It is advisable that married women who have albuminuria, should, by all means, avoid becoming pregnant.

RIGIDITY OF THE OS UTERI.

This painful accident in labor has been discussed during the past year. In two cases of the rigidity of the os, the internal administration of gelsemium, hot water sitz-baths, hot water douche streams directed against the os and cervix, and finally inhalations of chloroform were all used without avail; then a ten per cent. solution of cocaine was applied to the os, and dilatation occurred within five minutes. In these cases the labor terminated normally soon after the dilatation was effected. Some practitioners recommend tincture of lobelia inflata, but with this we have had no experience.

RECTAL INJECTIONS.—ENTEROCLYSIS.

As soon as convenient after the accoucher is called to a case of labor, already in the first stage, it is well to order a rectal injection of hot water, so that the lower bowel may be freed of all fæces present, thereby removing anything

like a mechanical obstacle, so that the child's head when passing down may have all the room possible. This proceeding is important, and in my practice it has been universally adopted for years past. Besides enlarging the capacity of the pelvic canal, it prevents absorption of excretory matters into the blood, as well as local contamination from the presence of any fæces, and materially increases the activity and tonicity of the labor pains.

DRY LABORS.

Occasionally we meet with cases where the bag of waters ruptures prematurely, and what otherwise would be a normal labor is converted into a tedious labor. Although heretofore such cases have been left to nature, yet a protracted labor is apt to be the consequence, and the forceps cannot be applied until the head has somewhat advanced. To make up for the premature evacuation of the waters, it is now proposed to inject water at a temperature quite warm into the uterus. To affect this, the parturient patient is to be placed in the Trendelenberg position, and with a fountain syringe the uterus should be filled with about one quart of water. The effect of this warm water within the uterus is to bring on the natural pains of labor, and thus overcome the uterine inertia. Cases are reported where this simple procedure has had a favorable effect, saving the application of the long forceps, and quickly ending a painful and protracted labor. In another instance of a dry labor the treatment was followed by a speedy delivery, where otherwise version had been resolved upon as necessary.

THE WALCHER POSITION FOR EXPEDITING LABOR.

There is a new maneuver in midwifery by which the capacity of the pelvic route through which the child passes into the world may be materially changed. Its object is to lengthen both the diagonal and true conjugate diameters

of the pelvis, by a change of posture in the lying-in woman, which I will presently describe. It seems that an Italian accoucheur in Venice, as far back as 1793, proposed that a woman when in labor should be placed horizontally upon a table, with her lower limbs hanging down over its edges. He claimed that by taking advantage of this position the forced extension of the legs increased the antero-posterior diameter of the pelvis, so that the delivery might be accelerated thereby. This proposal seems to have been forgotten or ignored by the profession, until Dr. Walcher, of Stuttgart, in Germany, seven years ago, called attention to it, which proves true the quaint saying of Sidney Smith: "It is not the man who first says a thing that deserves the credit, but he who says it so loud and so long, that at last he persuades the world that it is true." Dr. Walcher claims that there is a certain amount of mobility in the articulations of the pelvis, especially during pregnancy, and that the antero-posterior diameter of the pelvic inlet is not of a constant length, but varies with the position of the body. In other words, when the pelvis is extended by stretching the lower limbs and allowing them to be pendent over the edge of the bed, the conjugata vera measures from eight to thirteen millimeters—one-fourth to seven-eighths of an inch—more than when flexed upon the trunk. I am told that this lengthening has been verified by anatomists in experiments made upon the cadaver.* The usual position that we have been accustomed to adopt when we wish to apply the forceps, was to place the patient upon her back, with her thighs flexed upon her abdomen. According to Walcher, while a woman is in this position, the symphysis is inclined to approach the promontory of the sacrum, and the conjugata vera is thereby shortened at least six or seven millimeters. On the contrary, Walcher

* According to Professor W. H. Taylor,—*Cincinnati Lancet-Clinic*,—M. Crouzat, a Frenchman, has tested the Walcher position on cadavers, and found the diameter actually increased.

contends that when the thighs of a woman are forcibly extended, with the limbs pendent over the side of a bed, a certain degree of traction is exerted upon the anterior portion of the pelvis, and by this forcible extension the conjugata vera is lengthened some eight to thirteen millimeters. This increase in length of the antero-posterior diameter of the pelvic outlet will be at least one and a half centimeters. It is recommended to place the woman in this position, not only when instruments are necessary, but also in normal labors when the head does not advance, and we have a rigid perineum in danger of rupture. It can do no harm for the accoucheur to try this maneuver, and it has been stated that in lingering labors, after placing the woman in this position ready for the application of the forceps, that suddenly the pains have increased and the delivery has followed spontaneously, so that the forceps were not needed.

PROLAPSUS OF THE FUNIS.

More than twenty years ago Dr. Thomas recommended for a prolapsus of the umbilical cord, that the parturient woman should be placed in a reversed position—that is, in the genu-pectoral position. This was found to be a good suggestion, but the position soon becomes tedious, and as a substitute we now place her in the Trendelenberg position, which is far more agreeable for the patient, and decidedly practical.

Years ago Dr. E. R. Maxon suggested that in malpositions of the fetus, the mother should be placed in a reversed position, and he stated that in many instances thus treated, nature, unaided, would change the mal-position into a normal one. We find in the history of obstetrics that postural treatment for the correction of vicious presentations, and for hastening tedious labors, was recognized and taught as early as the first century, by Soranus, who seemed to have perpetuated and elaborated some of the teachings and the writings of Hippocrates.

A parturient placed in the Trendelenberg position will be at an advantage when we wish to make external version, and in trials made, this changed position has greatly assisted the accoucheur in effecting the turning. Dr. Newman, in his "History of Obstetrics," is our authority for the above, and adds: "The postural treatment, which is beginning to revive much merited attention to-day, has been intuitively followed by self-taught people, whenever they are free to follow their own instinct."

SMYPHYSEOTOMY FOR PELVIC DEFORMITIES.

During the past seven years the medical journals have contained accounts about the success of an operation first suggested by Severin Pineau in his writings in 1593. It is said that Pineau never carried out his proposal, but Sigault made the operation in 1777, and from this it was known in France as the Sigaultian operation. The operation thus made by Sigault was at first recommended and applauded by the faculty of medicine in Paris, but subsequently it was disapproved of by them. It seems to have been abandoned for about a century by accoucheurs in all countries except Italy, where it has ever been recognized as an admissible measure in the treatment of deformed pelvis. Notwithstanding this, it is said that the results in Italy have never been satisfactory. Of late it has been revived, and now it is recommended as a substitute for the Cæsarean section and craniotomy. Professor Dr. Sheldon Leavitt has made the operation with complete success, as both mother and child were saved. The statistics of the operation are still not complete, but I deem it worthy of mention, because we find cases recorded in the medical journals where it has been made with good results.

In deciding to resort to either symphyseotomy, or the Cæsarean section, the matter resolves itself into the question, who has the most right to existence?—when two lives are in danger and both are in doubt, but the mother's

most. For the past three years the trend of opinion in the profession seems to have been opposed to craniotomy, and in its stead they have recommended either symphyseotomy or Cæsarean section. When the patient and her nearest kin positively refuse to have either the Cæsarean section or symphyseotomy made, is it not then our duty, in order to save the life of the mother, to resort to embryotomy? To elucidate this most vital question, I quote from the rules of the late Professor Carl Braun, of the University of Vienna, as given by Professor Parvin.

“Cæsarean section on the living woman, for the preservation of the living fetus in pelvic deformity—in which the child, dead and diminished in volume, can be extracted through the pelvic canal, and the health of the mother can, with probability, be preserved by the perforation of the child’s head—is not permissible under the following conditions:

A.—When the parturient woman, with full consciousness, and without any direct coercion, declines Cæsarean section.

B.—When the parturient woman is rendered unconscious by disease, eclampsia, meningitis, apoplexy, etc.; by medicines, chloroform, ether, by poison, or intoxicating drinks.

C.—When the child’s life has been imperiled by uterine contractions, attempts at version, or the forceps, or when the child is deformed, or not viable.

Therefore, in extreme cases, such as are named above, where we can do nothing to save a mother’s life, except to resort to craniotomy, we have no other choice.

INDICATIONS FOR PREMATURE INDUCTION OF LABOR.

This operation is now permissible for pelvic deformity, grave heart, lung, or kidney trouble, when in the interest of either the mother or child; pernicious anæmia, severe chorea, advancing and incurable jaundice, incurable vomiting momentarily threatening the life of the mother; in

placenta prævia, in some exceptional cases of Bright's disease, and eclampsia; when the fetus is already dead in utero. In all such cases it is advisable to operate rather early, than too late.

ECTOPIC PREGNANCY AND EXTRA-UTERINE FETATION.

Extra-uterine pregnancy seems to occur more frequently the past few years than formerly. Some progress has been made in its treatment the past year, but the former practice, to destroy the vitality of the fetus in its abnormal position by means of either a powerful electric current, or by toxic drugs introduced hypodermically, has been quite changed and is now given up. The treatment most successful is to remove the fetus and its sac by laparotomy.

Extra-uterine fetation is usually a tubal pregnancy, and is accompanied with certain signs that indicate the existence of pregnancy. They usually have suppression of the menses, abnormal vaginal discharges, possibly a tinge of blood in the flow, with sudden and recurring excruciating pains, fainting, falling temperature, rapid pulse, pallor, rigors, and collapse. These symptoms should not be overlooked by the attending doctor, for if there is a tubal pregnancy, the sac is liable to suddenly rupture in the early months, and a fatal result may occur before the attendant can reach the patient. In such cases the only treatment is a rapid laparotomy, and complete removal of the cyst and its sac. Three such cases recorded by Professor Dr. R. Ludlam, are very interesting and instructive, and they all happened within one week. Two of them resulted fatally before Dr. Ludlam could reach them, and the third case was in a collapse—almost in articulo mortis—when the doctor arrived, but a rapid operation was made with complete relief, and the patient's life was saved.* The most

**The Clinique*, Chicago, June 15, 1896.—Article, "Ruptured Tubal Pregnancy," pages 325-331. We have seen no other papers upon this subject published in the current journals of the past year so interesting as these three cases.—T. G. C.

celebrated songstress and artist of the past twenty years, died thus suddenly in a collapse, from the rupture of a tubal pregnancy, the previous existence of which was not known. Her death occurred in Paris some years ago.

CONJUGAL REGULATIONS DURING PREGNANCY.

I would rather not mention this matter, and yet it is important to the welfare of every pregnant woman, although some may regard it purely as a question of *casuistry*, but physicians stand as "watchmen upon the walls," and we must not ignore it. As it has been plainly and elaborately discussed by so classic an authority as Professor Parvin, we will not apologize for its mention. Uncivilized and heathen nations have condemned it, and it should be forbidden by the accoucheur, who should advise that husband and wife occupy separate beds during the latter's period of gestation.

EXAMINATION DURING LABOR.

A celebrated authority says: "The ideal obstetrical art is to conduct a labor without even an examination or manipulation," and "careful midwifery should take the place of meddlesome midwifery." Nevertheless the accoucheur should examine his patient in order to make himself acquainted with the presentation and complete diagnosis of the case; if he discovers anything abnormal he should assist in its rectification, and favor the normal rotation, always with antiseptic precautions. Prophylactic disinfection, which has been advocated by some authorities, has been continued in eight, and done away in twelve, German obstetric hospitals. It is doubtful whether it is best to use even douches after a natural labor, where the after-birth comes away clean; but with unhealthy discharges dependent upon abnormal causes, with febrile conditions, douches may be properly administered.

CHLOROFORM IN LABOR.

For many years it was our custom not to give chloroform

unless some serious operative procedure was required. This course we have somewhat modified, and at present we give it frequently, especially toward the end of the second stage, to alleviate the last pains when the head is about to pass. It is not advisable to give it in the first stage, but for the severe pains of the second stage, it is a great comfort to the parturient and will do no harm. We unhesitatingly believe that, in labor cases, it is safer than ether. The important point about chloroform is to administer it properly, and it should never be given by any physician who has not had experience in its use. In cities it is customary for surgeons to employ a "chloroformer," who attends exclusively to its administration. Chloroform properly given diminishes shock, does not prolong labor, does not injure the fetus, does not favor uterine inertia, robs the mother of the dread of the pains of childbirth, and has no bad effect upon the parturient after getting up.

DIET OF PREGNANT WOMEN.

The proper food during gestation is an important matter, and for a healthy woman a diet somewhat restricted is preferable. A simple breakfast of a cup of tea or cocoa, oatmeal and milk, a little bread with butter, one egg, and a little fruit of the season, will be quite sufficient. For lunch, a bouillon soup of beef, mutton or chicken, with bread and butter, and fruit. For dinner, a small piece of meat, a little potato, or other vegetables of the season, stewed fruit, a plain dessert of cereals, and meat in a small quantity once daily is sufficient. Stimulants are not advised.

In summing up the treatment of puerperæ, I wish once more to insist upon absolute asepsis, and when this rule is observed, no strong antiseptic solutions for injections will be required. A healthy lying-in woman, delivered antiseptically, will need but little treatment during the puerperium. Simple diet, quiet in the confinement room, and if asepsis is kept up, nature will do the rest. In such a case even vaginal douches will not be required.

SHOULDER PRESENTATIONS, WITH REPORT
OF A CASE.

BYGEORGE E. PERCY, M. D.

THE indifference of our English medical ancestors to practical midwifery was responsible for the establishment of numerous practices in obstetrics, which can be accounted for in no other way than that they were evolved from unwilling minds dealing with most distasteful problems. As late as 1843, the Fellows of the College of Surgeons of England denied the right of admission to the council of the college to those who practiced the base art of midwifery, which was stigmatized as an art foreign to the habits of gentlemen of enlarged academic education. To the average practitioner of to-day, whose privilege it is to care for this previously neglected branch of medicine, such a conception of the duties involved in accouchement is as inconceivable as it was brutal, and we cannot wonder at the high rate of mortality (needless sacrifice of mothers and children), that will ever remain a blot upon the record of medical history, when we realize that the management of this high function was considered beneath the dignity of the practicing physician.

That the art of midwifery suffered materially for want of thoughtful application of the laws of physics and physiology, finds abundant proof in the radical change made in obstetrical operations within the last decade, and in none more manifestly than in the management of transverse or shoulder presentations.

Podalic version seemed to be the first and dominating thought of the older accoucheurs, even before the membranes had ruptured, and while the child was yet freely movable, a

proceeding which, in the light of recent progress, is rarely resorted to, and it can be safely said with a more flattering record of successful deliveries. The unfrequency of transverse presentations renders it quite impossible for physicians in private practice to confirm the superiority of any course of interference, since statistics show that only about once in 260 births does the shoulder present; it is, therefore, only at long intervals that we are confronted with this complication, and then we are prone to resort to old and tried methods, rather than to assume the seeming risk of a more reasonable course of less antiquity.

The fetus floating in the amniotic fluid, subject to the laws of gravity, in the great majority of cases, presents head down; but from various supposed causes—polyhydramnion, disproportionate lightness of the head, as in acephalic or hydrocephalic monsters; smallness of the fetus; death of the fetus; irregular form of the womb and relaxation of its walls, as well as abdominal flaccidity—transverse positions obtain, the head in either iliac region, more commonly face back; the breech on the opposite side above the ilium, and the shoulder at the os. We have then, roughly speaking, the head, the shoulders, and breech, each at the angle of a right-angled, spherical triangle, the presenting shoulder corresponding to the right angle, the head and breech to the other two. If we were required to remove a body of this shape from an inverted rubber bag, corresponding in shape to the uterus, we could easily succeed by making a fulcrum of the shoulder, upon which we would make upward pressure at the same time, with the other hand, using the more acute angle, representing the breech, as a lever to force the lower angle into the orifice; in this way by alternately pushing upward and inward on the lever, and toward the median line upon the lower angle, with the hand outside, we succeed in the operation with the least possible danger of injury to the body to be removed. Unfortunately, conditions are not

always favorable for such manipulations in the lying-in chamber, for a firmly contracting uterus, rigid abdominal walls, and absence of the liquor amnii, with a shoulder wedged in the pelvis, make it much more difficult to apply these principles, while they are nevertheless as truly applicable. The most important obstacle to overcome is rigidity of structures, inhibiting the free mobility of the fetus, and this we can frequently accomplish by due consideration of the position of the mother. I believe that the position should be varied to suit the various relations of the child within the uterus; for instance, when the head is in the left iliac the patient should be turned to the left, well over on to the chest and abdomen, the thighs well flexed. The genu-pectoral position, which has had several strong advocates, is unquestionably a good one, providing the patient is not too weak to maintain it.

Dr. Edward F. Wells, of Indiana, says of the knee-chest position: "With the parturient woman in this position, the abdomen is relaxed to the greatest possible extent, and the pains are less powerfully expulsive, the uterus is lengthened in its long and shortened in its transverse diameter, and the impacted shoulder is drawn away from the pelvic brim by the force of gravity.

"Correction of the mal-presentation is greatly facilitated by the shape of the uterus, and the ease with which any operative manipulations may be carried out."

While there may be a degree of optimism in thus summarizing the advantages offered by the application of the law of gravity to the malposed fetus, there is certainly sufficient truth in it to merit a test, and the fact that so experienced an obstetrician as Churchill records a mortality of 11.1 per cent. in mothers, and 52.1 per cent. in children would certainly justify our departure from older methods. In the beginning of labor, while the membranes are intact, and before the pains have become severe, a transverse position of the fetus might be, with comparative

ease, converted into a cephalic presentation by external manipulation while the patient is in the genu-pectoral position; but when, as frequently happens, our summons comes late, and we find the membranes long since ruptured, the shoulder firmly wedged in the pelvis, with an arm or hand protruding from the os, our patient in a highly excited and perhaps exhausted condition from the infrequent and agonizing pains, then it becomes imperatively necessary to avail ourselves of every possible mechanical and physical aid, which if well directed, will enable us, in a large proportion of cases, even under such unfavorable conditions, to engage the head and terminate labor in the normal way.

In order to avail ourselves of the advantage of posture, it is necessary that a careful diagnosis be made as to the presentation offered. There are symptoms noticed in the beginning of labor which should arouse suspicions of shoulder presentation; notably the gradual onset of pains coming on insidiously and less frequently than the pains in the first stage of natural labor; the high position of the os uteri, and absence of presenting part. On inspecting the abdomen the obliquely transverse oval is apparent at once, and by palpating the hard resisting tumor, the head is found at one extremity of the oval, and the more yielding prominence, the breech, at the other. Passing the hand along the upper margin of the tumor, a well defined convexity with distinct resistance indicates the back of the fetus, while an irregularly concaved surface with non-resistance shows the abdomen of the fetus to the anterior. Having ascertained the relative positions of the head and breech, and whether the back or the abdomen of the child is to the front, either of the four transverse presentations of shoulder birth can be readily determined. Thus, if the head is in the left iliac, back of the fetus to the front, the right shoulder is presenting. The head in the right iliac region, back of the fetus to the front, the left shoulder is presenting.

When we have thus determined the position of these three points—head, shoulder, and breech, bearing in mind the fact that the outline of the fetus corresponds roughly to the right-angled spherical triangle, it would seem reasonable to so alter the position of the patient that the uppermost part of the fetus, the long angle, shall by its own weight incline toward the perpendicular bisecting the right angle at the os. By raising the hips, and turning the patient well over to the sides corresponding to the fetal head, such a result is favored, and if this is supplemented by supporting the head of the child, the relief to the unnatural lateral distension of the uterus will do much to avert that dread complication, tetanic spasm.

The fact that flexing the thighs relaxes the muscles of the abdomen is too well known to deserve more than mention, but I doubt if the simple procedure is resorted to in obstetrical work as much as it deserves to be—when the pains are irregular and ineffectual, and it is desired to lessen their force.

Under these conditions, the favorable posture and relaxation of the abdominal walls, it would seem that nature had the best possible chance to remedy the faulty position of the child by spontaneous version. Dr. M. D. Wright was the first to call attention to advantages offered by cephalic over podalic version. His method has been practiced successfully in a great many instances during the past few years.

Following is a brief history taken from my notebook: Mrs. A. T., thirty-five years of age, mother of two children; labors were both normal, vertex presentation, well-developed children. Was called December 27, 4 A. M., patient having been in labor since preceding day. The nurse informed me that the pains had come on very gradually; the intervals between the pains being longer than she had ever noticed in natural labor. The membranes had ruptured during the night, and the patient was in a highly excited

condition, utterly wanting in the courage she had evinced in previous labors, being apprehensive to a degree which defied all my efforts to dissipate. The uterus was firmly contracted, revealing on inspection a well-outlined obliquely transverse tumor, the head in the right iliac fossa, and the back to the front; the pains were fast becoming more frequent, and their intensity more marked, their force being fully appreciated by placing the hand over the head and noting the strain upon the intervening structures. On digital examination I found the left shoulder firmly impacted at the pelvic opening, cervix well dilated. The patient on the back, the pains came with such frequency that it seemed to be almost a continuous spasm of the uterine and abdominal muscles, and any attempt to change the position of the fetus by external manipulation was absolutely futile. By turning the patient upon the right side, and flexing the thighs, I found there was a perceptible change in the frequency of the pains, and a considerable relief to the patient. In this position, introducing the right hand within the vagina, found it was possible by pressing the breech toward the median line, and alternately the head toward the pelvic opening, to effect a change in the position of the fetus. By continuing these manipulations in the intervals of the pains by slow degrees, the head finally came within reach of the examining finger, and by firm and constant pressure upon the breech, now in the median line well above the umbilicus, the head finally became engaged and the labor was terminated in less than thirty minutes, the presentation being the right occipito anterior. The child weighed about eight pounds, and while it showed the effect of the severe pressure to which it had been exposed, it soon regained its vitality, apparently none the worse for its exposure to the dangers attending transverse presentation.

I think it will be conceded that the prognosis in this case at the time of my summons was not altogether favorable, for we had to contend with the exhausted condition of the

patient, the absence of the amniotic fluid, a condition bordering upon tetanic spasm of the uterus, firmly impacted shoulder, and a living fetus of large size. Had podalic version been attempted in this emergency, it would have been well-nigh impossible to have succeeded without danger of rupture of the uterus.

In concluding these brief remarks, which I have been prompted to offer with the hope of affording a little courage to those who are called upon to assume the responsibility of these happily infrequent cases, of shoulder presentation, I would urge :

First. Early inspection.

Second. Careful diagnosis of the position of the fetus.

Third. Cephalic version by external manipulation, while the membranes are yet intact, with the application of a firmly applied abdominal bandage to maintain the position and assist labor.

Fourth. When the membranes are ruptured, and the shoulder is firmly engaged, turning the patient to the side corresponding to the fetal head, the thighs well flexed, and the combined manipulations upward upon the shoulder with the examining finger, and alternate pressure upon the breech toward the perpendicular bisecting the right angle at the os, and upon the head toward the pelvic opening, until the head is felt at the os, when the abdominal bandage should be adjusted firmly until the case is terminated.

THE TREATMENT OF SCARLATINA AND MEASLES.

BY

GEO. B. PECK, M. D.

DO homeopathists really practice homeopathy? This question ever imminent, has never been more significant than at present. That the professed followers of Hahnemann have not materially departed from his teachings during the century that has elapsed since he first publicly announced a method of cure based on natural law, will become plainly manifest to the most casual reader of the following facts:

Seventy-two per cent. of the members of the American Institute of Homeopathy are accustomed to administer prophylactics to those who have been exposed to the contagion of scarlatina; ten per cent. occasionally prescribe for them; and three per cent., when called for by patrons. Fourteen per cent., however, do not prescribe for persons until some indication of perturbed function is discernible. Considerably more than half my correspondents omitted to specify the medicament dispensed (for obvious reasons it was not asked for), yet it is certain that thirty-four per cent. resort to belladonna, a single individual only dropping as low as the tincture, and but two per cent. to the first decimal dilution. Three per cent. merely remarked they gave the indicated remedy; but *apis mellifica*, *mercurius iodatus ruber*, *psorinum*, and *sulphur* are each believed to be that magic drug by one per cent; while single individuals ascribe that fortunate attribute to *kali chloratum*, *rhus toxicodendron*, and *carbolic acid*, twelfth decimal.

Although the fact cannot be too often emphasized that any remedy may be demanded in the treatment of any

so-called disease, it may be alike interesting and profitable to note that the following drugs have been called for with the relative frequency indicated to combat the specific poison of scarlet fever:

Belladonna, 31.2; rhus toxicodendron, 11.0; aconitum napellus, 9.9; apis mellifica, 8.4; sulphur, 4.4; arsenicum album, 4.3; bryonia, 4.1; mercurius iodatus ruber, 3.9; mercurius vivis, 2.1; gelsemium, 2.1; ailanthus, 1.3; arum triphyllum, 1.2; mercurius iodatus flavus, 1.2; kali bichromicum, 1.0; lachesis, 1.0; pulsatilla, 1.0; veratrum viride, 0.9; mercurius corrosivus, 0.8; ferrum phosphoricum, 0.8; kali muriaticum, 0.7; phytolacca, 0.7; baptisia, 0.5; mercurius cyanatus, 0.5; calcarea carbonica, 0.4; mercurius solubilis, 0.3; kali hypermanganicum, 0.3; kali phosphoricum, 0.3; terebinthina, 0.3; stramonium, 0.3; hepar sulphuris calcarium, 0.3; ipecacuanha, 0.2; cantharis, 0.2; arsenicum iodatum, 0.1; tartar emetic, 0.1; carbolic acid, 12x, 0.1; allium cepa, 0.1; ammonium carbonicum, 0.1; lac caninum, 0.1; kresotum, 0.1; hyoscyamus, 0.1.

The following orders have been left by attending physicians regarding the diet of their scarlet fever patients. The figures indicate the percentage of the entire number of our practitioners who direct the use or disuse of any specified article during the acute stage of the disease. Milk, eighty-eight; broths, twenty-eight; gruels, nineteen; malted milk, fourteen; toast, ten; fruit and beef tea, each, seven; Bovinine and eggs, each, six; beef extracts, Mellin's food, and mutton broth, each, four; bread, soups, rice, grape juice, fruit juices, chicken soup, and oatmeal gruel, each, three; beef peptonoids, liquid foods, cereals, barley water, koumiss, buttermilk, rice water, liquid peptonoids, white of eggs, ice cream, and Imperial Granum, each, two; raw eggs, oyster broth, vegetable broth, farina porridge, prepared foods, oysters, peptonized milk, raw meat juice, beef juice, beef, beef broth, junket, corn starch, flour gruel, farinaceous diet, any suitable article, "nothing," and "no grease,"

each, one; custard, bean soup, milk punch, Best tonic, Matzoön, Murdock's food, Bovinine, starches, slippery elm tea, tapioca, soft foods, lithia water, albumen, lamb broth, granula, milk porridge, light chicken, sub-acid fruit, brandy and water, lemonade, olive oil, orange juice, baked apples, unbeaten raw eggs, rolled wheat, whole wheat gruel, cracker gruel, barley gruel, grape fruit, egg nog, toast water, blanc mange, panada, and oatmeal, each one-half per cent.; such also forbid coffee, tea, starches, spice, and meat.

By attention to the throat during an attack of scarlatina should be understood the use of sprays, gargles, or other topical applications to the more accessible portion of the alimentary canal. Thirty-two per cent. of our practitioners render *no such service* thereunto, and seventeen per cent. more, but *rarely*. As may be expected, those who employ such adjuvants confine not themselves to any single germicide, hence, while the number reporting the use of a given substance is correct, the proportionate number pursuing the practice cannot be ascertained by adding the several percentages. Peroxide of hydrogen is used to a greater or less extent by nineteen per cent.; alcohol and water by eleven; permanganate of potash and Listerine, each, by six; antiseptic gargles, "antiseptic sprays," hot water gargles, carbolic acid, and hydrastis, each, by two; hamamelis, salt and water, glycerine and water, boracic acid water, chlorate of potash, chloride of lime gargle, vinegar and water, pyrozone spray, and cleansing sprays and gargles, each, by one per cent.; while lime water, calendula, phytolacca, hydrozone, alcohol, and lemon water, acetic acid, cocaine spray, mucilaginous drinks, flour of sulphur, alum gargle, claret gargle, milk and water gargle, hot milk gargle, water and gum guaiacum, pinopin spray, alkaline spray, alkaline gargle, Dobell's solution, sulphurous acid, Seiler's tablets, a mixture of equal parts of chlorate of potash, glycerine, and water, another of alcohol and glycerine and water, a gargle of warm milk with creosote, and a gargle of hot water

containing a few drops of a mixture of iodine, one part, glycerine, eight parts, are mentioned by one-half per cent.

Children suffering from scarlatina are not bathed at all during the eruptive stage by twenty-three per cent. of our practitioners; rarely by nine; sometimes by two; and a half per cent. says "often." Twenty-six use tepid water (100° F.); eleven, hot water (110° F.); twelve, carbonate of soda water; seven, alcohol and water; four, plain water; two, luke-warm water; one carbolized water, acetic acid, ammonia water, borax water, cold water and castile soap; while one-half per cent. mention hot pack, alkaline baths, cold milk, boiled milk, luke-warm milk, hot milk and water, half and half, bran water, whisky and water, cider vinegar and water, if temperature is high, oatmeal water, warm olive oil, antiseptic solution, warm vinegar water, hamamelis, a Listerine sponge, and a cider vinegar water sponge, if the temperature be high. Another half per cent. bathes the extremities alone with tepid water. Where the temperature has not been stated, twelve per cent. will be found to prefer the tepid; four, the hot; two, 105° F.; one, each, 95° F., cool, and 60° to 80° F.; while one-half per cent. vaguely says warm.

Eighteen per cent. of our members *never* "grease" a scarlet fever patient, and eight per cent. more, but rarely. Six per cent., however, commence that ceremony on the first appearance of the rash; twenty-three, when the pruritus becomes annoying, and twenty-six when desquamation takes place. Still more definitely one per cent. select the fourth day for the inauguration, and one-half per cent. the fifteenth day. Olive oil appears to be the favorite unguent, for it is ordered by twenty-five per cent.; but vaseline follows closely with the endorsement of twenty per cent.; fresh lard used by fifteen; bacon by fourteen; carbolized vaseline by ten; cocoa-butter by nine; carbolized oil by four; cocoa-nut oil and lanolin, each, by two; cold cream, eucalyptus oil, carbolized cosmoline, calendula cerate, and petrola-

tum, each, by one per cent. ; while sweet almond oil, carbolized animal oil, vaseline $\frac{3}{4}$ j to thymol gr. j, carbolized cocoanut oil, glycerine and rose water, one to three, cold cream and glycerine, equal parts, rose water and lard, mutton suet, beef tallow, green olive oil, carbolic ointment, glycerine, carbolized cerate, camphorated oil, borated olive oil, half and half, and El Quito oil are mentioned by one-half per cent.

When owing to some specific neglect on the part of the nurse the eruption suddenly recedes, seventeen per cent. of our number meet the emergency with the remedy alone.

Of this number four-tenths per cent. state they never fail, although an equal number meet with little success, while the remainder affirm that their results are to be considered good. Seventeen per cent. resort to the hot bath as an adjuvant, though eight-tenths of a per cent. meet with little success. Twelve per cent. use the hot pack—one per cent. having little success, and four-tenths per cent. lose one quarter of such cases. Tepid baths, tepid packs, cold packs, and heat are employed, each, by three per cent. of the doctors with no complaint. The wet sheet pack and the pack (nature unspecified) are ordered, each, by two per cent., although four-tenths, representing each article, declare them unsatisfactory. A hot mustard pack, sweating, and a cold bath are each administered by one per cent., while a hot sponge bath, a hot corn pack, hot water to the extremities, sponge baths, a tepid sponge, a prolonged hot bath, elevation of the temperature three to five degrees, friction which never fails, a steam bath, which seldom succeeds, a ginger poultice, a cold flannel sheet, application of cold to the head, a hot mustard plunge, a hot mustard bath, a hot red pepper bath, immersion in salt water, and "a cold water pack frequently followed by a death certificate," are mentioned each by less than a half per cent.

Concerning medicaments, nine per cent. tersely state they give the indicated remedy, but twenty-one per cent. gener-

ally find that to be bryonia; six, cuprum metallicum; five, zincum; four, cuprum aceticum; as many sulphur, arsenicum album, and aconitum napellus; three, gelsemium, and as many camphor; as many ipecacuanha, and also veratum album; while less than half a per cent. mention veratrum viride, pilocarpine, arum triphyllum, exanthol, opium, calcarea carbonica, calcarea sulfurica, cocculus, cuprum arsenicum, ammonium, carbonicum eupatorium perfoliatum. Two per cent. mention the giving of hot drinks, a trifle over one per cent. cooling drinks, and less than a half a per cent. hot lemonade, copious draughts of cold water, and a hot sling.

Considering success in general, twenty-six per cent. meet with good; five never fail; four have little success; less than half a per cent. report moderate, and the same number a mortality of one-quarter.

When my tabulation was half completed, I became impressed with the number of those who reported they had never encountered a case, and it is a matter of deep regret the exact proportion is unknown.

Convalescent diet is ordered by thirteen per cent. of our doctors after the subsidence of the fever; while three per cent. more particularly designate that the temperature shall be down to 99° F. A like number recognize the supervention of desquamation as the proper indication for a change in the nourishment, while two per cent. wait until the rash has disappeared.

One per cent. wait until the close of the third week; less than half a per cent. to the close of the second, and an equal number only until the patient is out of bed. Twenty-six per cent. direct a light and nourishing diet; five per cent. simple food; as many a liquid diet; four per cent. a reasonable diet; three per cent. a farinaceous diet; two per cent. a generous diet; as many a semi-liquid bland diet, also ordinary diet.

Eggs are recommended by eight per cent.; fruit, milk, and broths by six; bread and toast by five; cereals by four;

soups, rice, custard, baked potatoes, and gruels by two; cooked fruit, oranges, baked apples, bananas, rare beef, meats, solid food, lamb stew, young pigeon, malted milk, steak and beef broth with rice by one; mushes, crackers, sago, chicken, grape juice, onions, oysters, prepared foods, cocoa, beef juice, currant jelly, beef peptonoids, beef tea, fish, eggs, oatmeal, spices, farinaceous foods, and sweets, each, by one-half per cent.

When the bath is recognized as a proper accessory treatment for scarlatina, it is first administered after desquamation by twenty per cent.; at the beginning of desquamation by six per cent.; when desquamation is three-quarters completed by two per cent.; after the eruption has disappeared by as many; and also after the fever has declined; on the fifteenth day, by one per cent.; and at the end of the fourth week, when the temperature becomes normal, on the forty-second day, and two weeks after the eruption, by one-half per cent.

Ten per cent. make it of tepid water, and five per cent. of hot water; four direct a sponge bath; two use soda water, as many soap and tepid water, and also carbolized water; one per cent. prefer alike a hot salt water bath, a bran bath, a bichloride of mercury bath, and an alcohol and water bath; one-half per cent. order soda and borax, hot soap and water, a tepid alkaline antiseptic, a boracic acid, an ammonia sponge, and a warm salt and water sponge bath respectively. Where the temperature is not mentioned in the preceding list, two per cent. have the liquid hot, and three per cent. tepid.

It is gratifying to announce that more than ninety-three per cent. of our members have not varied the management (treatment) of their scarlet fever cases through deference to current theories as to the nature of the disorder. While it is true that here and there one remarks that he has made some change in diet, or dropped some antiseptic in the bathing water, or scattered some germicide in ill-looking

throats, the ringing declarations of devotion to a law of nature that has withstood the storms and assaults of a century are ample proof that the rank and file of the profession will never be enticed from the rock of eternal truth by the vagaries of so-called science, however brilliant and specious they may appear.

Their experience has proved the truth of Hahnemann's assertion, that whoever works as he worked, will attain the same results.

The history of medicine during the past five years—not to say the last two thousand—amply proves that a knowledge of the causation of disease affords no assistance to the accomplishment of its cure.

Fifty-seven per cent. of the members of the American Institute of Homeopathy inflict neither "powder" nor "grease" upon patients suffering from measles; twelve per cent. rarely do so; fourteen per cent. omit powder; and twelve per cent. omit grease. Ten per cent. only answered the question affirmatively. Vaseline is ordered by ten per cent. of the doctors; olive oil by eight; old bacon, lard, carbolized vaseline and cocoa butter, each, by three; sweet almond oil and cosmoline, each, by two; carbolized olive oil and camphorated oil, each, by one; carbolized sweet almond oil, lanolin, glycerine and rose water, calendula cerate, carbolized glycerine, cocoanut oil, and phytolacca cream, each by one-half per cent. Starch is used by four per cent., talc and corn-starch, each, by three; rice flour, rye flour, and buckwheat, each, by two; flour and boracic acid, each, by one; Fuller's earth, zinc oxide, arrowroot, bran, and resorcin, each, by a one-half per cent.

During an attack of measles, eight per cent. of our practitioners do not order bath, and four per cent. but rarely.

On the contrary, twenty direct their use at the beginning of the attack; eleven per cent. after the appearance of the eruption; ten upon the disappearance of the rash; seven when desquamation occurs; eight when the patient is con-

valescent; four when restless; three after the fever has subsided; one per cent. each on the seventh day and the sixteenth day,—when there is no excessive itching,—and two weeks after the eruption has disappeared; one-half per cent. on the fifth day, on the eighth, on the twelfth, and after the catarrhal stage.

Concerning their nature, twenty-nine per cent. say they use tepid water; sixteen per cent. a sponge bath; ten per cent., a hot bath; six, a soda bath; three, alcohol; and as many warm soap and water; two, a cold sponge; one, alkaline baths, water carbolized, and bran baths; one-half, lukewarm milk, sponging, alcohol and water, half and half, a bichloride of mercury bath, tepid water and cider vinegar, tepid alkaline antiseptic bath, warm salt water bath, with antiseptic soaps, boiled milk, cold milk and water, half and half, antiseptic bath, and a warm foot bath. Concerning the temperature of those not particularized, twelve per cent. order them tepid; seven per cent. hot; one per cent., 80°F.; and as many 105°F.; one-half per cent., 90°F., and as many lukewarm.

Furthermore, one-half per cent. resort to carbolic acid water, when the eruption is well out, to cold water if the temperature is high, to an agreeable temperature of the bath whether hot or ice cold; if in the second stage, to a sponge bath if the fever be high, and to hot salt water if the eruption is too dark or lasts too long.

It may not be unprofitable to note the variety of foods prescribed during an attack of measles in the order of the frequency of use. Milk is ordered by seventy-one per cent. of our doctors; broths by twenty-three; gruels by sixteen; malted milk by eleven; toast by ten; beef-tea by seven; rice, fruit, and eggs, each, by five; cereals by four; bread, chicken broth, oatmeal gruel, mutton broth, and soups, each by three; grape juice, beef extracts, fruit juice, Mellin's food, Bovinine, liquid peptonoids; and "anything," by two; cooked fruit, oyster broth, potatoes, farina porridge, beef

juice, peptonized milk, buttermilk, toast water, lamb broth, barley water, koumiss, cocoa, ice cream, custard, beef broth, jelly, light puddings, and granum by one; bean soup, onions, prepared foods, meats, Best tonic, raw meat juice, starches, oranges, rice water, baked apples, tapioca, lemonade, and raw egg, corn starch pudding, egg and milk, whey, junket, albumen, flour gruel, granula, alkathrepta, white of egg, arrowroot, egg nog, albumen water, wheat-germ, grape fruit, rolled wheat, blanc mange, beef broth, with rice, wheatlets, cracker gruel, whole wheat gruel, beef peptonoids, panada, mush, milk and whisky, and barley gruel, each, by one-half per cent. Certain physicians preferred, however, to employ more general terms, to wit: a light and nourishing diet by eight per cent.; a liquid diet by six per cent.; a reasonable diet by two per cent.; a farinaceous diet, a liquid and bland diet, and a mild diet, each, by one per cent.; a semi-solid diet, and a generous diet, each, by one-half per cent.

To the victim of measles the following beverages are permitted by the number of practitioners respectively indicated: Water, generally cold, and to any extent desired, by eighty per cent.; lemonade, twenty-three; tea, eight; orangeade, five; and as many milk; fruit water, four; grape juice and toast water, three; coffee, flaxseed tea, barley water, rice water, crust coffee, mucilaginous drinks, plain soda, warm drinks, hot lemonade, fruit-juice, and "none," by two each; cocoa, aerated water, acidulated drinks, crushed ice, vichy water, tamarind water, orange juice, cider, apollinaris water, ginger ale, and cambric tea, by one each; orange leaf tea, hot punch, whisky occasionally to allay cough and promote sleep, ice cream, apple water, chocolate ice water, tea with lemon, buttermilk, currant jelly water, hot water, hot water and cream, berry juice, slippery elm tea, lithia water, claret, milk, seltzer, egg lemonade, sherry and eggs, cold milk and water with salt and sugar, brandy and milk, cream of tartar water, acetic acid water, cham-

pagne, milk punch, hot water and milk, pop-corn water, one to three, after standing fifteen to thirty minutes, and any cool drink, one-half per cent. One per cent. forbid, each, stimulants, coffee, and tea, while one-half per cent. each prohibit hot drinks, cold drinks, and ice water.

The relative frequency with which remedies are prescribed during measles is *pulsatilla*, twenty-three per cent.; *aconite*, twenty-one; *bryonia*, twenty; *belladonna*, six; *gelsemium*, five; *euphrasia*, three; *rhus toxicodendron*, *ipecacuanha*, sulphur, tartar emetic, each, two; *mercurius vivus*, *hepar*, *arsenicum*, phosphorus, and *ferrum phosphoricum* each, one; *mercurius solubilis*, *veratrum viride*, *sanguinaria*, *sticta pulmonalis*, *drosera rotundifolia*, *kali bichromicum*, *rumex crispus*, *kali muriaticum*, each, by one-third per cent.

It may be desirable to call attention once again to the fact that all the numerals in this paper are percentages of the ordinary homeopathic physician, except in the two paragraphs giving the remedies for the cure of the respective disorders mentioned, where they indicate the number of times a particular drug is given in every hundred prescriptions, taking the entire country as the field of observation.

A STUDY OF THE PLACENTA.

BY

P. J. B. WAIT, M. D.

AS the study of the plant begins with the germination of the seed, so a study of the placenta begins when the vivified ovum drops into the decidual soil, there to be nourished, developed, and retained until maturity. The seed germinates, the plant grows, its fruit ripens, and falls by reason of having completed its cycle; the placenta likewise has its season of germinating, rooting, growing, and developing regularly and systematically, then of ripening, ready to drop at the end of its season, easily as the fruit drops from the tree or the nut from its rind. Any deviation from its regular rule is due to absence of healthful conditions, the result being a blight which is more or less disastrous to both mother and child.

Someone says: "Too little is known of diseases of the placenta," but, as a fact, too little is known of the placenta, whether in health or disease. The busy doctor, when labor is over and the placenta delivered, feels that his duty is done, and the placenta is left to incineration, often without an examination to find whether the membranes were delivered entire, or whether any fugitive piece may have been retained to produce hemorrhage or more direful results. True, testimony which the placenta gives is always *a posteriori* in character, but from such testimony so much may be gathered that the intelligent obstetrician cannot afford to be without it.

All such testimony carefully secured and reported would add valuable resources to our treasury of obstetrical knowledge.

Every warm-blooded viviparous animal, as well as the

human creature, owes its fetal existence to that complex, yet simple, fetal appendage called the placenta; and vigor of the fetus depends as clearly upon a healthy placenta as vigor of the child depends upon proper tone of the lungs and stomach. Oviparous creatures also have an analogue of the placenta, it being a placenta in a modified form, and more nearly corresponds to the umbilical vesicle, which precedes the placenta in embryonic life. The placenta in its embryonic stage completely surrounds the ovum, being in the form of the surface of a sphere, at which time it is an example of the diffused placenta of certain quadrupeds. The delicate rootlets of the chorion penetrate the entire surrounding decidua, as rootlets of the plant push into the soft mold to draw up nourishment for the stalk.

The ovum with its countless rootlets reminds one more of plant than of animal life, and an inspection of it at this time shows a parallel between plants and animals, more close than at any other period subsequent to the original cell from which all life, whether plant or animal, springs. The umbilical vesicle which precedes the chorion, points to parallelism running through all forms of animal life, the best example of which is seen in the newly hatched fish, though it can also be observed in partially incubated egg.

The placenta is by all authors conceded to be the most important fetal appendage, while differences of opinion are noted as to both its anatomy and physiology.

After the atrophy of the embryonic villi over a large portion of the ovum, the fetal placenta gradually increases in size up to the end of gestation, when it resembles, in shape, a cake, for which reason it receives its name, and is nearly circular, from six to eight inches in diameter, one or two inches thick at the center, tapering out to the membranes at the circumference, and weighs from half a pound to a pound and a half. It is most frequently attached to the uterus at the upper posterior part, being often found at the left angle, and is made up of a fetal and maternal

portion, which always remain distinct. The maternal side is formed of fetal tufts highly developed, which dip down into the decidual membrane, so that the smallest rootlet receives its proportion of oxygenated maternal blood, while the fetal side is smooth and glistening, receiving the branches of the umbilical arteries, which divide and sub-divide, finally dropping into the substance of the placenta by the intervention of the chorion, and following the ultimate ramifications of the fetal villi. The blood is returned by a number of veins, which gradually converge to form the umbilical vein in the cord.

Very close analogies to the human placenta are found in all viviparous creatures. From Fleming's "Veterinary Obstetrics," I gather that the placenta of animals with a solid hoof, like the horse, covers the entire ovum as the shaggy coat covers the human ovum prior to the fetal placenta.

From its shape it is known as the "diffused" placenta. On the ovum is found a bare spot, which corresponds to the os uteri, that affording no place where it can attach itself, but such spots are seldom found at any other point. The swine has a diffused placenta, which differs from that of the mare by being arranged in tufts or clusters, but these are so closely grouped that the ovum is entirely covered. In ruminants, as the cow, the placenta consists of a great number of tufts (sixty to eighty), known as placental or fetal cotyledons, varying in size, but oval in shape. These tufts correspond to prominences upon the inside of the uterus, called maternal cotyledons, which are covered by the decidual membrane or serotina. The maternal cotyledons are not a growth following impregnation, but exist in the uterus of the young animal prior to that condition. Sheep and goats have multiple or tufted placenta, but the maternal cotyledons are depressed instead of elevated, as in the cow. Placenta of the canine and feline species are arranged about the ovum in the form of a band, and

from their shape are known as annular or zonular. The decidua in these animals seems to be an extra layer of the mucous membrane, which cleaves off as a distinct membrane after the birth of young.

Whatever the form of the placenta, its functions remain the same, and gives interesting proof of a striking analogy existing in all forms of animal life. The student of comparative anatomy has but to know the variety of placenta to tell to what class of creatures it belonged, or conversely, what variety of feet an animal has, to describe the placenta which it would develop.

Anatomically, the placenta is not difficult to comprehend; its mystery is in its power to interchange material between the oxygenated maternal and carbonated fetal blood through the subtle process of osmosis. Compare this process, as much as we may, to that which goes on in the lungs of warm-blooded animals, between the blood in the capillaries about the air cells and the external air, or to the blood in the gills of the fish and the air in water in which they float; it is far more difficult to grasp and will always remain one of the most incomprehensible of the many mysteries of reproduction.

The blood of the mother and that of the fetus never meet, neither has their ever been traced any nervous connection between the uterus and placenta, yet no fact is better known than that of the intimate nervous sympathy existing between the pregnant woman and her unborn child. Racial and facial marks, as well as tastes, habits, and dispositions, even to minor idiosyncracies, follow the child up and down through life like the grip of death, making one almost doubt the free moral agency of human beings. Yet these impressions reach the child only through the intermediary of the nerveless placenta, between which and the maternal blood an impassable barrier forever exists. Whatever can be said for or against the so-called "mother's marks," no one has ever penetrated this nerveless station,

between mother and offspring, deep enough to explain how the entire body of the child can be so unhappily affected through maternal sources, and yet a particular part of the child's body be not so affected.

A fetus was brought to my clinic the past winter, of which almost every member and organ, outside and in, were shockingly abnormal.

It was the second child of the kind born to healthy German parents, to whom normal children had also been born. When so much can be effected through the mother's blood on one side and the placenta on the other, who can say that less or more may not also occur to the unborn child?

If the root of the plant be vigorous, the plant itself should be strong and hardy, and these two conditions presuppose a healthy and fertile soil, so, if the chorionic villi be healthy, the fetus also should be strong and vigorous, which presupposes a normal, well-nourished decidua. Unfortunately, it is difficult to determine where diseases of the decidua leave off and those of the placenta begin. The villi are known to be liable to diseases in early embryonic life—many an embryo being sacrificed before the end of the second month, probably about the end of the sixth or seventh week.

Getchell most clearly describes these chorionic diseases. One of the most rare and interesting is manifested by drop-sical effusions into the villi, being known as the "hydatiform mole," and was first described by Velpeau, who was born in 1795, began the study of medicine in 1816, and became professor of clinical surgery in the Academy of Medicine, Paris, 1835. It was probably then, after he was forty years of age, that he discovered and described this disease. The fluid contained in the vesicles, which vary in number and size, is usually colorless, though sometimes reddish, and is albuminous in character. The life of the embryo is destroyed from inanition, and being so small, the

body is dissolved and disappears. Another disease of the villi is due to obliteration of the canal into the villus, producing an atrophic condition exactly opposite to the dropsical. As no circulation occurs into these villi, they very soon undergo fatty degeneration, giving the ovum a fibrous or opaque surface, quite unlike its normal appearance, and constitutes what is familiarly known as a blighted ovum, with the embryo often dissolved as in the hydatiform variety. If but a small portion of the villi is diseased in this way, the fetus may go on to maturity, when these fatty villi may be seen as small isolated cotyledons around the periphery of the placenta, which itself may be healthy, over almost its entire surface. I had the pleasure of examining a specimen of this kind some months ago. There were a number of these fatty degenerate masses just outside the margin of an otherwise well-developed placenta. Calcareous degeneration had begun in the placenta itself, so that the entire surface was gritty, as though sprinkled with coarse sand, but the child was lively and strong.

The point to be made is that two opposite conditions appearing in early chorionic life are sure, if extensive, to destroy the embryo, and in proportion as the placenta is infringed by the fibro-fatty condition, to that extent the life of the fetus is endangered, but that of the mother is not affected.

This condition is difficult or impossible to diagnose, as all authors agree; it may, however, recur in the same patient, when a feebleness or failure of fetal movement—after having been once established—might indicate a recurrence of the former lesion.

By a rupture of some utero-placental vessel, blood may be diffused between the decidua and the chorion, thus compressing the entire villi and destroying the embryo, which may be dissolved before the expulsion of the ovum. A very interesting case of this kind came under my observation in the anatomical room of our college, hemorrhage

evidently having been the cause of death, the ovum still being intact. Later in gestation hemorrhages may be confined to the placenta, and are dangerous in proportion to their extent; any considerable amount destroying the life of the child. Women once affected by this condition are apt to suffer recurrences at subsequent pregnancy.

Dropsy, atrophy with fatty or fibrous degeneration, and hemorrhage seem to menace the ovum in its embryonic stage, as the grub menaces the root of the young plant—each and all of them being as destructive to the embryo as the grub to the plant; but we search in vain for authentic causes of these various enemies of the ovum, or for any sure means of preventing them. Syphilis, probably more than all other plagues, makes its destructive mark upon the placenta.

If the mother be affected before pregnancy, the decidua and placenta show gummatous growth, and proliferation of the connective tissue of the villi occurs, which finally obliterates the blood vessels.

Placenta and cord finally become impervious by reason of the vessels and sinuses being encroached upon, and the fetus dies from lack of nutrition. The placenta and cord tell their own story, while the dead fetus is a sad commentary upon this monstrous enemy to fetal existence. Whether any remote syphilitic strain, handed down from a forgotten source, may not be responsible for much "non-specific" placental or chorionic diseases, is not known, and I find no reference to such possible origin, but suspect that such may be the case.

Finally, to return to the vegetable kingdom for a simile, if the seed be imperfect, no variety of soil will overcome the imperfection enough to produce perfect plants, so, though the uterine decidua be healthful and the ovum normal, vivification by imperfect material will result in a blight which will be likely to follow one or other of the

forms already mentioned, while, other things being normal, an unhealthy decidua would produce similar results.

Three elements, then, are necessary to produce perfect placentæ, a healthy decidua, perfect ova, and normal spermatozoa.

Either one wanting, a blight early or late results; if early, the chorionic villi are destroyed and the true fetal placenta is never reached; if late, a morbid placenta, with a diseased or dead child pays the penalty.

Can anything be done to overcome placental diseases? No haphazard treatment will remove causes rooted deep enough to again and again destroy the product of conception, but believers in our law of cure, by faithful study and careful application of the law upon their patients, may, without doubt, in time, improve the decidual membrane, help the ovaries to better products, and, not forgetting that the father oftentimes needs treatment as well as the mother, give tone to the vivifying principle. All three being correct, diseases of the placenta within our ranks should become practically unknown. Then, and not until then, will the slaughter of the innocents due to placental diseases come to an end.

HEREDITARY SYPHILIS IN INFANTS.

BY

JOSEPH PETTEE COBB, M. D.

I DO not propose to open the question of how the syphilitic virus is transmitted from parent to offspring, or which parent, if either, has the greater responsibility in the matter. A brief *résumé* of its manifestations in infancy only is the scope of this article.

The more common form of tissue change which takes place in hereditary syphilis is a diffuse interstitial hyperplasia of the connective tissue; circumscribed gummata are much less common than in the acquired form.

The visceral organs liable to be affected, and in their ratio of frequency are the spleen, pancreas, liver, lungs, testicles, and kidneys. In the case of each organ, as stated above, the lesion is usually an interstitial hyperplasia of connective tissue, which increases the size and density of either the whole or some part of the organ, and which encroaches upon the essential cell structure of the organ, thus impairing its physiological capabilities. These lesions, when not too extensive, are often amenable to treatment.

The bone lesions are of two types, viz., osteochondritis and osteoperiostitis; both lesions are more liable to involve the long bones. Osteochondritis is a lesion belonging to early infantile manifestations, while osteoperiostitis is the form of lesion usually observed later on toward the period of puberty. Osteochondritis is peculiar to syphilis, and starts, as its name implies, at the zone of proliferation between the bone and epiphyseal cartilage; it may materially affect the growth of the bone; it is apt to be symmetrical. The number of bones involved appears to be in direct ratio to the virulence of infection, and the greater number

of bones involved, the graver are the infant's prospects of life.

Besides these common types, dactylitis frequently occurs, when the fingers or toes may swell to twice their normal size, assuming a peculiar pyriform shape.

Upon the skin we have lesions of the type of erythema, maculæ, papules, vesicles, and pustules. It is quite characteristic of syphilis to have a variety of skin lesions co-existing: blebs appearing either at birth or in the first months of infancy upon the palms of the hand or soles of the feet are characteristic lesions. Catarrhal inflammations of some part of the mucous membrane of either the respiratory or alimentary tract, or both, are present; mucous patches may be found in the mouth or pharynx, and fissures at some of the muco-cutaneous margins.

The nervous system is liable to suffer as a result of hereditary syphilis; the lesions of these tissues may appear in infancy, childhood, or in adolescence. They correspond to the tertiary stage of the acquired disease, but are often the first or only manifestations of the inheritance.

Intracranial syphilis may appear as a diffuse meningitis, as localized gummata or as endarteritis. It is characteristic of any of these forms of lesion to develop slowly and to be accompanied by little or no fever. The meningitis may evidence itself for several weeks, only by more or less constant headache in various parts of the head; later paralysis of some intracranial nerve may appear, with evidences of a severe intra-cranial affection.

The symptoms produced by syphilitic gummata do not differ from those produced by any localized tumor, and their recognition as such must depend upon the presence of other syphilitic manifestations. Endarteritis is especially liable to affect the arteries at the base of the brain; it may lead to local dilatation, with a thinning of the arterial wall, and result in a hemorrhage; there may be produced an occlusion which cuts off the blood supply, and results in

in more or less softening and disintegration of cerebral tissue. The symptoms will, of course, vary in accordance with the part of the brain affected; the most common are the various forms of paralysis of the extremities and sensory disturbances. Any of these forms of the disease are similar conditions not depending upon syphilis. Syphilis of the spinal cord may present itself as an obliterative endarteritis, or as a general arteritis; it may or not be associated with the same condition in the cranium. More often syphilis of the cord is associated with a sub-acute or chronic meningitis or meningo-myelitis. The important features to bear in mind in either of these forms of the disease are:

- (1) The unusual distribution of the disease over the greater part of the chord.
- (2) The slight intensity of the affection at any one level as compared with the extensive areas involved.
- (3) The rapid improvement of some symptoms and the persistency of others.
- (4) The frequent history of other manifestations of the disease elsewhere.
- (5) The fact that they have a tendency to improvement and an equal tendency to relapses.

Clinical History.—Under the influence of the syphilitic poison the fetus often ceases to grow, dies, and is expelled long before term; it may be born prematurely, and show marked indications of the disease when it comes into the world; or it may be born at term, but dead. About seventy per cent. of stillbirths are due to syphilis; in such cases the fetus is usually macerated, and may show bullæ.

The clinical course of the disease presents itself in two rather pronounced types, the early, occurring in infancy, and the late type, as observed toward puberty.

The early symptoms correspond to the secondary stage of acquired syphilis. In the severer types the infant shows at birth, or within a few weeks after birth, an efflorescence of the skin; this efflorescence has a predilection for the nates,

the parts around the genitalia, the palms, and the soles. A simple erythema represents a mild form of the disease, while papules and pustules each indicate a severer type of infection; blebs are found only in pronounced cases, and when occurring on the palms and soles are very characteristic.

Together with the efflorescence there is present, or early develops, a persistent excoriating coryza; complete occlusion of the nares may occur. The cry is hoarse, weak, and often only a plaintive whimper. The child is small, poorly developed; there is an absence of any subcutaneous fat; the skin is dry and hangs in folds, the face has an old, anxious expression. Syphilitic infants rarely look happy, never smile, and are very fretful. Persistent fretfulness and crying at night are in themselves always suggestive of hereditary syphilis.

These children always manifest evidences of indigestion. Dyspeptic diarrhea, with foul-smelling excreta containing mucus and undigested food, is the usual accompaniment of this disease. All of the excreta, including the perspiration and breath, are foul smelling, and a peculiar, penetrating odor clings to the child even after its bath. These digestive symptoms are in part due to catarrhal inflammations of the stomach and intestine, and in part to the lesions of the digestive glands, the liver, spleen, and pancreas.

Syphilitic lesions of the mouth in early infancy consist of mucous ulcerations on the cheeks, tongue, and lips; they are more or less painful and sluggish in repair. Those involving the lips are apt to select the commissures of the mouth, and produce deep fissures with indurated bases; these are known as rhagades. As a result, in part, of the impaired digestion, we may have various forms of stomatitis engrafted upon these mucous sores, which do not represent purely syphilitic lesions.

These children usually show osteochondritis of some of the long bones. So commonly is this the case that some authors claim that the diagnosis of this early type is not

made until this is found. Children are frequently born apparently healthy, showing no evidence of impaired nutrition or other lesions until some months after birth, when characteristic syphilitic lesions make their appearance. It is claimed that the virus may remain latent till the sixth month, but certainly in the great majority of cases it develops before the close of the third month of infancy. The symptoms do not differ from those which we have described as appearing immediately after birth, and may go on to the same fearful extent. As a general rule the later the symptoms begin to appear, and the slower they develop, the more amenable are they to treatment and the less severe they become.

All cases do not show the typical lesions of the disease, and in mild cases there may be doubt as to their character. A persistent acrid coryza, even without mucous ulceration; persistent, dyspeptic, foul-smelling diarrhea, with emaciation; an old expression, with wrinkled, anxious face; persistent fretfulness with insomnia, are all classical symptoms. If any of these conditions are present, together with an enlarged liver and spleen, there can be little doubt of their significance; when osteochondritis is found, all doubts are removed.

A large proportion of syphilitic children die, but many who present very grave lesions, and who develop the lesions early in infancy, do not succumb to the disease. The most important point in their care is to maintain their general nutrition.

This is not always easy to do; the mother often does not have sufficient breast milk to satisfy their wants, and when the mother herself has been a sufferer from the disease, her milk is very frequently an insufficient food. Artificial foods are often prepared with no appreciation either of the child's wants, or of its feeble digestive powers. The more an infant's digestion is impaired, the harder it becomes for him to digest casein; fat and sugar are what they need,

and cream and sugar of milk are what they can digest with the least effort. I have found a simple cream mixture which does not contain more than one per cent. of casein, four per cent. of fat, and seven per cent. of sugar of milk, the best food for them and the most likely to be well digested. Where a milk laboratory can be called upon for aid, there is no trouble in obtaining the desired proportions. Where fresh cow's milk can be obtained, with a little intelligent assistance, we can make a good substitute milk. Good cream contains from sixteen to twenty per cent. of fat, and one to four per cent. of proteids; diluted with five or six parts of water to one part cream, it will give a fair proportion of fat. Sugar of milk should be added in the proportion of $3\frac{3}{8}$ drams to every 8 ounces of the mixture.

Much discussion has taken place as to the relationship between rachitis and syphilis, and between tuberculosis and syphilis. Rachitis is essentially a disease of malnutrition, and anything which so profoundly affects the nutrition as syphilis can undoubtedly influence its development. The characteristic born lesions are entirely different, and it is not an unusual thing to find both lesions existing in the same case. A syphilitic parentage, where the active evidences of the disease have been overcome, may transmit a weakened constitution, which less easily withstands the deprivation and unhygienic surroundings which are the progenitors of rachitis.

Tuberculosis, like syphilis, is a disease of civilization, and some researches which have of late been made seem to show that tuberculosis follows syphilis; that not until syphilis has weakened the natural resiliency of a race, is it liable to tuberculosis. In the individual case, we know that an organism which has suffered the ravages of syphilis, either acquired or hereditary, offers a suitable soil for the development of the tubercular bacilli.

The medicinal treatment of hereditary syphilis is as varied as the manifestations of the disease. I am not one

of those who find in mercurius the sole or even the most frequently indicated remedy. Mercurius does not cover all of the symptoms of secondary syphilis, and almost none of those of tertiary stage; hereditary syphilis presents conditions and symptoms corresponding to the second and third stages of the acquired disease. Mucous ulcerations, characterized by extensive inflammation and swelling, will demand mercurius; also some forms of dyspeptic disorders and bone lesions with nightly aggravations.

The catarrhal inflammations are more apt to demand some of the various kali preparations. Hereditary syphilitic symptoms, like the kali pathogeneses, are characterized by the absence of a low grade of fever. Kreosotum will often control the foul-smelling diarrheas and rob the child of its usual peculiar penetrating odor. It is also of service in controlling dental caries, and in healing the cracks and fissures at the commissures of the mouth.

The iodide of potash is a valuable remedy with which to arrest the progress of lesions of the glandular, the nervous, and the osseous systems, but it can frequently be well followed or replaced by the iodide of calcarea, or the iodide of arsenicum, in lesion of the glands; by silicea, or zincum, or sulphur, in those of the nervous system; and by hepar sulphur, alum, or nitric acid, in those of the osseous system.

Mezerum, thuja, or sulphur are remedies frequently required to clear up the various skin manifestations.

Strictly homeopathic medication will yield the best results in the treatment of hereditary syphilis, and we do not need very often to resort to so-called antidotal treatment.

ALBUMINURIA OF PREGNANCY.

BY

FLORENCE N. S. WARD, M. D.

THIS paper will include: First. A review of recent investigations as to the ætiology.

Second. Clinical significance as deduced from an analysis of the reports of 552 cases observed in five of the largest maternity hospitals in Germany.

Third. Personal experiences.

Fourth. Deductions.

Owing to the present unsettled condition of medical opinion as to the nature of albuminuria, we are still forced to call the diseased condition of which albuminuria is one of its most constant and visible symptoms, by the name of its chief symptoms, either albuminuria or eclampsia. Throughout the paper eclampsia will be included under albuminuria—the position taken being that eclampsia is but a secondary condition, or culminating manifestation, of a diseased condition of which albuminuria is the prodromal. That rare form of eclampsia will be excluded, which is purely of an epileptic type, in which no renal complication is manifest, as demonstrated by absence of albuminuria in the urine.

Albuminuria holds a very similar pathological relation to pregnancy that puerperal fever does to the puerperium.

In each, it is the gravest complication that can arise, ranging from the lightest to the severest type; in each the prognosis is always guarded. Each is an infectious process, differing from one another, however, in that albuminuria is an infectious process from *within*, or an *auto-intoxication*, while puerperal septicæmia is an infection from *without*. Menge and Kronig's latest investigations show

conclusively that septic auto-infection in the puerperal condition is an impossibility. When the cause and true nature of albuminuria will be as clearly understood as puerperal fever now is, likewise will our results in preventing and controlling it be equally good.

As soon as we touch upon the *ætiology* of albuminuria of pregnancy, we enter a debatable land, where many investigators have vigorously labored to support their various theories, and though it is but fifty years since modern investigation upon this subject first began, multitudinous theories have been advanced and refuted. Investigators in seeking for the causes of albuminuria and eclampsia have pursued their researches on four different lines :

First. Changes within the kidney.

Second. Pressure upon the ureters, including increased abdominal pressure from the gravid uterus.

Third. Eclampsia bacillus.

Fourth. Changes within the nerve centers.

1. It was in 1843 that Lever tried to prove, from a number of cases of puerperal eclampsia observed by him, that the seizures generally occurred with the appearance of a large amount of albumin in the urine. This dates an epoch in the study of this disease, and the acceptance of the relations between the eclamptic manifestations and a simultaneous occurring renal disorder. Lever's conclusions were the only ones for many years, and were in fact the foundation, more or less, of all that followed. In 1851 Frerichs gave to the public his famous treatise on Bright's disease of the kidneys and its treatment. He considered eclampsia nothing more than a uræmic intoxication, due to the accumulation of an abnormal amount of urea in the blood and its transformation into ammonium carbonate. Litzneau and many other noted scientists believed this correct, until Scanzoni and Petrof showed, by experiments upon animals with carbonate of ammonia, that his conclusion was incorrect.

In 1863 Rosenstein tried to supersede the theory of intoxication by another published in his book, "Ueber Pathologie und Therapie der Nierenkrankheiten." He still held to the conclusion that the disease was a kind of uræmia, but ascribed a different cause to the uræmia, and allowed that the only pathological condition found in the kidney was that of engorgement. Virchow agreed with him.

Spigelberg and Coenheim next differentiated eclampsia from eclampsia without albuminuria; they held that eclampsia with albuminaria was due to retention of excrementitious materials within the system. The other form was due to epileptic tendencies.

2. Halbertsma tried to prove by post-mortem demonstration that the disease was the result of retentio urinæ, due to the compression of the ureters by the gravid uterus.

Lochlein agreed with Halbertsma; in 8 out of 32 cases that terminated fatally, Lochlein found characteristic changes in the ureters clearly marked, dilatation above the pelvic inlet—the place where the strongest pressure is brought to bear by the gravid uterus.

Olshausen believes, not so much in the direct pressure of the gravid uterus upon the ureters, as the increased abdominal pressure, the result of the pregnancy acting deleteriously upon the ureters and kidneys.

3. Scarlini, from examinations of the blood, the urine, and the secretions of the intestines of women whose death was due to eclampsia, had succeeded in isolating a bacillus. He claimed he produced eclamptic convulsions in pregnant dogs by injecting the bacillus. The blood had a poisonous effect, and contained ptomaine products. Egerdes, in a most interesting treatise, claims to have isolated the eclampsia bacillus, claiming infection takes place from the uterus.

4. Among those whose investigations led them to believe that the nerve centers are chiefly at fault, were Ostoff and Lantos, who placed the cause in the nerve centers,

particularly the medulla oblongata, reflexly excited by the pregnant uterus.

Schröder considers cerebral anæmia the cause, while Schauta holds that acute circulatory changes are responsible, causing anæmia or hyperæmia of the brain.

Wernich, Brown-Séquard, and Zweifel hold that there are epileptic zones or peripheral centers of excitation in the genital organs. Galabin and Leiblinger, as well as Otto Von Herrf, consider that the eclamptic symptom depends upon a change in the excitability of the eclamptic centers of irritation, induced by gestation and excited by urate poisons, lead, alcohol, or infection.

CLINICAL SIGNIFICANCE.

Though experimental research and theoretical deductions may lead us through a maze of uncertainties when we look upon the clinical picture of a disease, all observers agree as to certain clear-cut characteristics that pervade all cases.

Individual opportunities are rarely large enough from which to draw general deductions, and it is to hospital experiences that we must turn for this study. The most interesting clinical facts to be found in modern medical literature on this subject are furnished in the reports of 552 cases that occurred in different hospitals in Germany under the most favorable opportunities for clinical observation.

They are divided as follows: 200 cases of eclampsia that occurred in the Royal University Hospital for Women, in Berlin, September 1, 1865, to April 17, 1891, by Professor Olshausen.

Report of 129 cases in the University of Leipsic, by Professor Zweifel.

Report of 81 cases observed in the Royal Hospital for Women, in Dresden, from September 30, 1883, to June 1, 1891, under Professor Leopold.

Report of 80 cases in the Women's Clinic of Frederic William's University of Berlin, from 1882 to 1887.

Report of 62 cases in the Obstetrical Hospital of Königsberg from 1866 to 1882. In only one report is the frequency of eclampsia noted as compared with normal cases. Professor Leopold found that the total of deliveries during that period amounted to 10,718, out of which there were 81 cases of eclampsia, .75, or 1 to every 133.

The preponderance of primiparæ attacked was noted in all reports:

	PRIMIPARÆ.	MULTIPARÆ.
Olshausen, .	74 per cent.	26 per cent.
Leopold, .	86.42 "	13.58 "
Klinik at Königs- berg, }	85.1 "	14.9 "
Frederic Wil- liam's Hospital }	83.75 "	16.25 "

Making an average of 82.31 per cent. for primiparæ and for multiparæ 17.68 per cent., or almost *fivefold greater frequency among primiparæ than among multiparæ*, which agrees with other observers.

	PRIMIPARÆ.
Winchel,	76.79 per cent.
Lantos,	78.57 "
Lohlein,	85.4 "
Braunn,	86.3 "
Scanzoni,	79.4 "
Kopetsch,	75 "
Schauta,	82.6 "
Getthard,	85.1 "

Twin pregnancies were noted as more frequent. They occurred in 6.47 per cent. of cases as compared with the usual proportion of $1\frac{1}{4}$ per cent. The amount of amniotic fluid was noted as unusually large in only one case; in the others the distention of the uterus was not exaggerated.

Clinically, what is the relation of albuminuria to eclampsia? The per cent. of cases having albuminuria are as follows:

In Professor Olshausen's clinic, 32 out of 200; no mention is made of the condition of the urine, a circumstance partly explained by the inability to obtain urine from the patient by catheter. The remaining 168, with the exception of one, showed albumin in the urine.

In Professor Leopold's clinic, albumin was found in 90.79 per cent. of cases. In Frederic William's University, albumin in 79 out of 80 cases. In Königsberg's Hospital 37 cases were examined for albumin, and in every case more or less albumin was found. Professor Zweifel found albumin in all his cases.

Similar results have been reported from other clinics :

Winckel,	84	per cent.
Schauta,	85.6	"
Lantos,	91.3	"
Ingersley,	92.21	"
Lohlein,	96.22	"

Unfortunately, a complete record of the microscopical examination of the urine has not been made; all agree as to finding granular and hyaline casts in all cases examined microscopically.

Among 20 that died in Professor Leopold's clinic, 1 was without, 1 with but very little albumin, and 15 with very much albumin in the urine.

Thus in the *fatal cases, the amount of albumin in the urine was considerably greater on an average, and the occurrence of albumin more regular altogether, than in the lighter cases.*

Besides, a closer connection between albuminuria and eclampsia appeared to be evidenced by the fact that recovery took place *sooner*, and all symptoms of eclampsia disappeared more quickly, the sooner the albumin disappeared from the urine.

Œdema was found in 178 cases out of 423 recorded, making a percentage of 42, therefore *eclampsia was associ-*

ated with albuminuria in the majority of cases, and with œdema in almost half the cases.

Unfortunately the information regarding hereditary taint is too inexact to be of value. It was noted that when eclampsia passes off during pregnancy, it is not likely to occur during subsequent delivery. The re-establishment of eclampsia during some later birth is a great rarity, though in Leopold's Hospital two cases are recorded of albuminuria and eclampsia in succeeding pregnancies. As to the symptomatology of the prodromal stage, the chief symptoms noted were œdema, gastric pain, headaches, attacks of dizziness, desire to vomit, great restlessness associated with increased nervous irritability; cutaneous hyperæsthesia, occasionally amaurosis, and a symptom observed by Professor Olshausen of loss of memory, or amnesia, from before the attack until recovery of consciousness during convalescence.

Mortality.—The average rate of mortality in the five hospitals was $22\frac{1}{2}$ per cent.; and although fivefold more primiparæ than multiparæ were affected, the mortality was twice as high with multiparæ as with primiparæ.

The prognosis is *most favorable where eclampsia sets in during the puerperium; least favorable during pregnancy; and stands between both extremes when the period coincides with the time of childbirth.*

Among the symptoms of the greatest prognostic importance is the *pulse* pre-eminently; secondly cyanosis, dyspnœa, and sopor; also the seizures,—not only their number, but their duration and quick succession,—the condition of the urine, and the temperature.

Fatal cases were those where the pulse remained rapid, was subject to rapid alterations in regard to fullness and regularity. Whenever this condition of the pulse continued for any length of time, or when there was lasting cyanosis and dyspnœa, the indication was urgent to deliver the mother as soon as possible.

It was proven that complete emptying of the uterus favors the subsidence of convulsions; *this is more marked the milder the means* adopted. Eighty-five per cent. of the convulsions ceased on emptying the uterus.

The *prognosis* must always be doubtful, not only during the attack, but the sequelæ must be considered; among which affections of the lungs (pneumonia) and septicæmia play the most important part. The frequency of sepsis among eclampsia patients is proven throughout the hospitals. The prognosis for the child is less favorable than for the mother. The life of the fetus is even more endangered than that of the mother by the rapid sequence of the attacks. It was noticed that after twelve to fifteen attacks the fetus had ceased to live; often much sooner.

Occasionally after more than fifteen attacks, a living child was born, but as a rule, these children died a few days after birth.

The mortality of the children through the hospitals was:

Professor Leopold's Hospital, . . .	37.6 per cent.
Professor Olshausen's " . . .	28 "
Frederic William's " . . .	36.25 "
Königsberg " . . .	38.1 "
Making a total average of 35 per cent.	

PERSONAL EXPERIENCES.

Personally, four cases in private practice have developed albuminuria during pregnancy to such a degree that the urine in each case became solid, or almost solid, on boiling. Three cases out of the four were primiparæ, the fourth was a multiparæ.

CASE I. Primipara; age twenty; pale, waxy complexion. Gives history of grandmother having had eclampsia. Patient anæmic before marriage. Pregnancy uneventful, until within a few days of labor, when œdema and albuminuria suddenly set in. When labor began the pains were weak and irregular, the patient heavy and partially coma-

tose, but no seizures; instrumental delivery; small child; albumin disappeared rapidly in the course of a few days. Patient has since borne two children without return of albuminuria.

CASE II. Primipara; age twenty; blonde. History of chlorosis before marriage; pelvic disease after; received local treatment until she became pregnant. Three weeks before the expected confinement suddenly developed general œdema and albuminuria. Was put to bed, placed upon milk diet and remedies, and everything done to relieve the kidneys; pulse was very miserable throughout, running from 120 to 140 much of the time; at term she was delivered of a small, weak child, that lived several months, but finally died of meningitis. The patient has since borne another child, and had no symptoms of the previous albuminuria.

CASE III. Mrs. M., aged thirty-four, multipara; no hereditary history, menstruation normal; married eleven years; has had four living children and four miscarriages; the last a three months' miscarriage, taking place in January, 1893, followed by retained placenta and profound septicæmia, from which she made a slow recovery. In June, 1893, I performed for her a trachelorrhapy curetting, as she had a very severe cervix laceration and endometritis dating from her first labor. The operation was followed by good health until March, 1894, when she menstruated for the last time, and a little later a diagnosis of pregnancy was made. On September 23, 1894, six months from the time of her last menstruation, she was taken ill with pains in the chest, back, and head, œdema and vomiting of greenish fluids. After being ill from Tuesday to Saturday morning, she was seized with eclamptic convulsions, having three in rapid succession, followed by coma. The urine was found to be solid with albumin on boiling, the pulse rapid and small. Active measures were at once instituted to bring about a better action of kidneys and skin by applying heat to the back,

wrapping her in hot blankets, securing free catharsis and giving gels. Under this remedy, and later, kalmia, as indicated by change of symptoms, she gradually improved for about a week.

Then blindness appeared, beginning in the right eye, and gradually growing worse. Then the left eye became involved, and almost complete amaurosis supervened. During this time she complained of headache, frontal and occipital, pain across chest, backache, gastric distress, insomnia, and nervous restlessness. The fetal heart being indistinguishable, the fetal movements having ceased, in the interest of the mother the indication was to empty the uterus.

On October 28, 1894, under chloroform, and with the strictest antiseptic precautions, the cervix was forcibly dilated, followed by the introduction of a bougie. Labor took place in twenty-four hours (pulse, 100, temperature, 102°) and progressed normally until the patient was delivered of a macerated seven months' fetus.

Pulse, immediately after the fetus was delivered, was 122, and weak. There was a decided amelioration of all her symptoms, except the blindness, and but slight diminution of albumin in the urine; two days after delivery there was three-fourths volume of albumin. The amelioration of the kidney condition was very slow, as the record of the case showed two months later that albumin was one-fourth volume; the microscopical examination showed granular hyaline and blood casts; one month later the records show albumin one-tenth volume, total disappearance of casts. Her improvement was constant in every way after this.

Ophthalmoscopic examinations of the eyes were made by Dr. E. R. Byrant, November 12, 1894, and revealed the following conditions: Disks swollen, hazy, and hyperæmic; edges ill defined; cribriform plate invisible; general appearance of light grade of choked disk.

Arteries about normal in size and appearance; veins distended and tortuous. Color of retina darker than normal.

Numerous hemorrhages and white fatty spots in both eyes.

Right eye.—Number of white spots, characteristic of albuminuric retinitis, irregularly scattered between the disk and the macula lutea. The largest and most uneven quadrangular-shaped spot about the width of the disk, and about a third longer than it, situated external to the disk, near the macula. Several smaller white patches above and below the macula, and internal to it, one of which encroached upon the edge of the macula.

Left eye.—Greater number of hemorrhages than in the right eye. Number of irregularly shaped degenerative white patches between the disk and macula, and scattered about the latter. White spots smaller than those in the right eye, and macula comparatively free from them, although one almost touches the macula.

Subsequent examinations showed a gradual improvement in the color and appearance of the disk and retina.

The blood was gradually absorbed, and the white spots have slowly disappeared.

February 13, 1895. Unaffected parts of the retina and disks returned to about their normal condition. Here and there are small pigment spots marking the position of the degenerative patches. In one or two places the bare sclera, surrounded by pigment, is to be seen through small holes in retina and choroid; some of the larger white spots still show traces of the fatty degeneration, and are as yet to be distinguished by their light color in comparison to the surrounding comparatively healthy retina.

VISION.

November 12, 1894. Right eye, 1-12. Left eye, 1-24 (1 letter).

December 10. Right eye, 2-36. Left eye, 2-24 (1 letter). Both eyes, 2-18 (3 letters).

January 30, 1895. Right eye, 2-18 (3 letters). Left eye, 2-12. Both eyes, 2-9 (4 letters).

February 13, 1895. Right eye, 2-18 (3 letters). Left eye, 2-9 (2 letters). Both eyes, 2-6 (2 letters).

Patient was discharged cured a year ago, and lost sight of until a few days ago, when she reported as not having menstruated since February, 1896, and feeling very badly with severe gastric disturbances. On examination a diagnosis of pregnancy was given. Microscopical and chemical examination of urine show .05 per cent. of albumin, and hyaline and granular casts, with pus and blood corpuscles. What course shall be pursued? Already a pregnant nephritis is established, and the question arises, Shall we take the risk of inducing abortion, sacrificing the child for the sake of avoiding the calamities that seem almost certain to arise if the pregnancy is allowed to progress? This patient shows in a remarkable degree an intolerance to endure pregnancy. Though to all appearance a sturdy Scotch woman, yet of the four children that were born alive, only one is now living.

CASE IV. Mrs. F., age twenty-six, married five years, sterile, no hereditary taint. Menstruation had always been very painful. Physical examination revealed an ante flexion of the uterus, conical cervix, pinhole os, stenosis, tubes and ovaries normal, general health perfect. She had divulsion performed, followed by amelioration of the dysmenorrhea, and later pregnancy ensued; her last menstruation taking place August 8, 1894.

Her pregnancy proceeded normally in every way until March 26, 1895, when she reported at the office on account of general œdema, headache, and spells of dizziness. The urine on boiling was almost solid. The patient was immediately put to bed, every means were used to stimulate diaphoresis and diuresis, and apis was given internally. In two days the examination of the urine showed:

Specific gravity, 1012.

Quantity in twenty-four hours, 1440 c. c. m.

Urea eliminated, 1.1 per cent., or 15.8 grains.

Albumin, 1.2 per cent., or 15.8 grains.

Microscopical examination showed many hyaline and granular casts, some epithelial casts, renal and bladder cells.

The same treatment inaugurated at the beginning was maintained through the fifty days of pregnancy that followed, labor taking place May 15, 1895. An accurate daily record was kept : first, quantity of liquids ingested ; second, quantity of urine passed in twenty-four hours ; third, amount of urea eliminated ; fourth, amount of albumin, and fifth, the microscopical examination. The daily examinations were most carefully made by my assistant, Dr. Sophie Kobicker.

It is interesting to note the changes that took place. In three days the amount of urea eliminated arose from 15.8 to 21.6 grains ; the albumin decreased from 1.7 per cent. to .65 per cent., and the casts became fewer in number. The quantity of fluid ingested daily was maintained between 2000 and 3000 c. c., by so doing the quantity of urine voided each twenty-four hours was kept above the normal average, or 1200 to 1400 c. m. daily.

The albumin in the total amount averaged 5 per cent. daily ; the lowest amount was six days before delivery, 3.8 per cent., or 5.47 grains, from which point it gradually rose until the day of confinement, when it reached its highest limit of 25 per cent. The elimination of urea was maintained above normal, and averaged between 20 and 30 grains with but few exceptions.

With the increase of albumin six days before confinement, a simultaneous decrease of urea was noted, the smallest amount being 1.2 per cent., or 11.52 grains. Daily microscopical examinations showed the constant presence of granular and hyaline casts. It was noted that whenever the bowels became torpid the amount of urea was immediately diminished, the albumen increased, with immediate headache and dizziness, and active measures had to be instituted at once to relieve the system. The labor

was normal in every way, and the child, though small, weighing only four pounds, was healthy and well, and still alive.

The progress after confinement was excellent, the albumin immediately fell to 2 per cent. (urine drawn by catheter). The microscopical appearance constantly improved until a month from the birth of the child; only occasionally could a hyaline cast be discovered, and the albumin had diminished to .04 per cent. Later examinations showed the kidney had returned to its normal condition and the patient is now in perfect health. The remedies used in this case were apis, which did the most efficient work; kalmia later for pains and aches through her body; sulphur, indicated by her symptoms, a constitutional remedy, and later chin. arsen. for anæmia resulting from loss of albumin.

This case illustrates what can be accomplished by conservative measures in saving both mother and child, providing the physician keeps thoroughly in touch with every point of the case and is prepared to act promptly at the first signal of danger.

DEDUCTIONS.

As to the nature of albuminuria of pregnancy and eclampsia, the evidence adduced by experimental research, by clinical observation, and personal experience cannot fail to present the disease in a clearer light, and give us the means of deciphering the underlying cause that produces and maintains it.

One of the main causes for the failure of investigators to arrive at satisfactory conclusions, to my mind, is largely owing to the narrow view that is taken of the disease, and the tendency to center upon *some single organ* as the one at fault, and attribute to it all the varied phenomena of the disease. We, as homeopaths, with our interpretation of disease as the *morbidly disturbed vital force that affects*

every part of the body, can entertain a large conception of this disease when its manifestations are brought before us for interpretation.

Bouffe's researches on "*Lesions Anatomique que l'on trouve dans l'eclampsie puerperale*" throws much light upon the subject. He found upon *post-mortem* examinations that the pathological lesions of patients dying from eclampsia are peculiar to themselves; they are found in no other disease, and are as distinct as the *post-mortem* lesions that characterize typhoid fever. He found that profound changes take place in all the internal organs, primarily the liver; secondarily the spleen, kidneys, heart, lungs, and blood. The changes were the same in all parts. First, there were *hemorrhages into the tissues, followed by degeneration of the parenchyma of the organs*. These changes accord more nearly with the profound manifestations of an eclamptic attack.

The theory that the kidneys are the only organs at fault, that the lesion is similar to Bright's disease, is not borne out by clinical evidence. If an organic disease of the kidneys, why do the casts and albumin disappear with such rapidity, usually in two or three days after the delivery of the child?

If dependent upon pressure upon the ureters, or intra-abdominal pressure, why does the disease not occur more frequently, or when large abdominal tumors are present?

Clinical observation has shown that the fetuses in albuminuria are not large, nor is the quantity of amniotic fluid great; on the contrary, the children are much below the average in size.

As for the eclampsia bacillus, when numbers of reliable observers can isolate a clearly defined and characteristic bacillus of eclampsia that is capable of producing this disease with all its characteristics and pathological lesions, then may we believe in the eclampsia bacillus, but hardly before.

ADDRESS BEFORE THE AMERICAN INSTITUTE ON OBSTETRICS.

BY

HENRY EDWIN SPALDING, M. D.

IN looking over the past year of work in obstetrical observation and research, we discover nothing that will mark it in history as a milestone in the progress of science, but we do find that a vast deal has been done all along the line of this extensive subject.

Studies of **ovulation** (1) and **menstruation** show that either function may take place independently of the other.

While menstruation is usually accompanied by ovulation, there may be the hemorrhage without ovulation, and true ovulation may take place at the normal period, and probably at other times, without the appearance of the menstrual flow.

Ovulation and **fecundation** have been studied, and experimental (2) observations seem to show that it is quite possible for an ovum to escape (3) into the free peritoneal cavity, and then be taken up by the tube of the opposite side; that the cilia of the tubes may exercise their propulsive functions independently of excitation incident to menstruation or coitus.

The physiology and pathology of gestation have received much attention. The question of **maternal impression** (4) has been taken from the field of mystery and popular superstition, and carefully considered by some of our best authorities. From their deductions, it seems to be proved that both physical and mental defects may follow maternal impressions.

Ventro-fixation and **vagino-fixation** have been recognized methods for treating uterine displacements—a suf-

ficient length of time has now elapsed to enable some accurate data to be obtained as to the resulting effect on subsequent pregnancies and deliveries.

During pregnancy many have complained of pain at the site of fixation, nausea has been more severe and persistent, and the percentage of abortions seems large. At delivery, the dystocia resulting from these operations has been a frequent source of difficulty and danger. The large number of transverse positions is specially marked. This is accounted for from the fact that the fixed position of the fundus forces the womb to expand transversely rather than longitudinally. Of 54 cases (5) under one observer, about 10 per cent. had this mal-position; in nearly 22 per cent. obstetrical aid was required; in nearly 4 per cent. delivery could only be accomplished by Cæsarian section.

This set of cases seems to show a fair average of obstetrical complications resulting from ventro-fixation. The effect of vagino-fixation on parturition seems to be still worse, as might be expected.

Of 12 cases (6) nearly 50 per cent., delivery was most difficult. In 3 of these podalic version was resorted to. In 2 this could not be accomplished. In both, the head was in a diverticulum of the anterior wall of the uterus, and although in one instance perforation and the cranioclast were resorted to, in neither could delivery be accomplished until a free incision had been made in the anterior lip of the cervix and the adherent vagina. All of the mothers were saved; two of the children were lost.

In view of these facts, the propriety of performing either of these operations upon a woman who is liable to become pregnant is questionable, and the obstetrician demands that the gynecologist shall first try faithfully all other means for restoring and maintaining a displaced uterus in its normal position, and that these disabling operations be made only as a *dernier ressort*.

While **symphyseotomy** continues to provoke discussion,

it appears to maintain its high position in the confidence of the profession. From statistics derived from the work of many operators, of varying skill, and including cases done under the most adverse circumstances, there seems to be a maternal mortality of 10 per cent., and a like heavy loss of children. Under the hands of the most skilled operators, and with aseptic surroundings, the maternal mortality has been between 2 per cent. and 4 per cent.; the infant mortality still remaining large. In comparison with Cæsarian section of Porro, the death rate is vastly in favor of symphyseotomy; and this including cases where the former was deemed too hazardous, and the case would otherwise be left to craniotomy and the necessarily complete infant mortality. The chief argument in its favor is, that where theoretically induction of labor would be demanded, with its attendant, immediate or remote, large infant mortality, gestation may be allowed to progress to term, when 70 per cent. (8) will be delivered without incident, and with little or no loss of children.

It might be here remarked that, in speaking of the relaxation of the **sacro-iliac synchondroses**, Braun (7) claims to have seen the symphyses as movable in young *primiparæ* as when symphyseotomy has been performed. In the Walscher position, the hips being brought near the edge of the bed with the legs extended and allow to hang over, this condition is taken advantage of.

It is claimed (8) that by this maneuver, the antero-posterior diameter at the brim is increased between 1 and 1½ centimeters.

The latest new method of managing a case of **placenta prævia** is by **Cæsarian section**. It is possible that a case might be found where this would be justifiable. To say nothing of the extra hazard in which the woman's life would be placed from the operation itself, it does not seem possible that in a case of active, profuse hemorrhage, anyone would attempt to postpone interference while prepara-

tions could be made for the capital operations of Cæsarian section, and when the diagnosis has been made before active hemorrhage has set in, there should be little difficulty in delivering with comparatively small danger to mother and child.

Puerperal septicæmia continues to demand attention. Prophylactics have become greatly simplified by a more general reliance upon strict and perfect cleanliness, rather than upon the use of germicides. Douches are less generally used, except where a rise in temperature and, perhaps, a putrefactive character of the lochia indicate the presence of sepsis. The value of asepsis and antiseptics has been proved by the study (10) of births during the five pre-antiseptic years from 1868 to 1872, and the five antiseptic years, twenty years later, from 1888 to 1892. The study covered 231,000 cases. The deaths from puerperal infection dropped from 1.3 per 1000, during the first five years, to 0.8, nearly one-half, during the last five years. Without doubt, this is due to the radically improved hygiene of the puerperal chamber, in which asepsis and antiseptics play a most important part.

The value and safety of the **curette** (11) is questioned by many, and the aseptic index finger urged as the best instrument for the detection and removal of retained morbid material. **Hysterectomy** is being urged by the surgical contingent of the profession as the most promising treatment for puerperal fever. Lusk (12) favors it in cases of pyæmia due to infected thrombi; J. M. Baldy, (13) urging, says, "Why wait until a second chill, if a reasonably positive diagnosis can be made earlier?" He reports one seemingly critical case in which, while the tubes and ovaries were unaffected, the uterus was large and soft, and thrombi were found not only in the uterine walls, but all through the veins of the broad ligaments, which were removed close to the pelvic walls. The woman recovered. To the impartial mind the case does not offer much in favor

of the operation, for that the sepsis was not cured by taking away the uterus is shown by the fact that on the fourth day after the operation she had a severe chill, with a temperature of 105° , higher than ever before, and later had an attack of phlegmasia. He had collated nineteen such operations, with twelve deaths. Dr. Tuttle (15) finds twenty cases reported, with fourteen deaths.

The advocates of this radical treatment unanimously urge that, to warrant the best results, an early operation is demanded; that the disease must not be allowed to advance beyond certain limits; but just what these boundary lines are, they do not clearly define. One (11) claims that it is useless where the disease had spread beyond the uterus. Another (16) that for the acute, rapidly progressive and virulent forms of the diseases occurring early in puerperium, the operation has thus far been a failure. For the ulcerative or suppurative metritis, usually appearing in the later part of the puerperium, it has been a brilliant success.

These opinions would seem to indicate that hysterectomy meets with brilliant success only in those cases in which medicinal, curettage, and other non-heroic treatment likewise meet with brilliant success in saving nearly all cases. A careful analysis of the cases so far published would seem to warrant the obstetrician's saying to the hysterectomist, "Hands off."

Serum therapy does not fail to come to the front as a cure for puerperal septicæmia. The cases thus far reported are too few to show any conclusive evidence for or against its efficacy. Dr. Vinay (17) has used the anti-streptococcic serum taken from a horse immunized against diphtheria, he thinks with good results. This serum is useful only in cases coming from streptococci, having no effect upon septicæmia due to other bacteria. But since the most virulent forms of the disease arise from streptococci, he thinks it advisable to use it in all cases, because to be efficacious it must be used early, and the time spent in making cultures

to discover the special variety of bacteria present might carry the patient beyond relief. It is advised, wisely I think, that other treatment, both local and general, be vigorously applied at the same time.

The possibilities held out by the Roentgen rays as an ally of the obstetrician in making a correct diagnosis in ectopic gestation, as regards position, multiple pregnancy, fetal dystocia, from malformation or tumors, raise our liveliest anticipation as to what the observations of the coming year may bring forth.

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Book Reviews.

All manuscripts for publication, and all books for review, in this journal should be sent to the Publication Office, 133 William Street, New York.

TRANSACTIONS OF THE AMERICAN PEDIATRIC SOCIETY.
Seventh Session. Edited by FLOYD M. CRANDALL, M. D.

This small volume, which has been carefully edited to prune off all superfluous words, contains numerous articles of value to those interested in pediatrics, most of which have been published in *Pediatrics*.

THE INTERNATIONAL MEDICAL ANNUAL AND PRACTITIONER'S INDEX. A Work of Reference for Medical Practitioners, 1896. Fourteenth Year. E. B. Treat, New York.

The fourteenth volume of the International Medical Annual, under the conjoint authorship of thirty-nine distinguished American, British, and Continental authorities, is one of the best issued, containing in compact form the cream of medical literature which has appeared during the past year, including a review of therapeutics for the year, together with descriptive articles on the new remedies, with clinical indications for their use; a dictionary of new treatment, giving a complete index of diseases, and showing the latest methods of treatment, both medical and surgical. It is trite to say that it should be in the possession of every physician, but it is nevertheless true that it is a very valuable work, and thoroughly deserves its great popularity. It is fully illustrated by colored plates and photographic reproductions.

THE PRACTICE OF MEDICINE. A Condensed Manual for the Busy Practitioner. By MARVIN A. CUSTIS, M. D. Philadelphia, Boericke & Tafel, 1896. Half morocco, \$2.00.

This very handsome volume, delightful to the eyes, printed in clear, readable type upon thin, dull paper, contains within its 367 pages a compact treatise upon the practice of medicine. It may be slipped into the pocket to be studied in leisure moments,

and will often serve to refresh the memory regarding treatment of the more common conditions, for the majority of cases are treated, and cured, by remedies selected by inspiration—inspiration, as Innes understood it. He painted, he said, by inspiration, but he had to work like a slave to get material for inspiration. This book of Dr. Custis is a capital storehouse whence to draw material for inspiration. In the description of the diseases the latest definite views of ætiology and pathology have been given ; and, in the treatment, only those remedies are mentioned that have a definite relation to the disease treated of. The indications for the remedy are full and clear, and the list of remedies complete. In many cases the authority for the indications is given.

TWENTY-FIFTH ANNUAL REPORT OF THE MIDDLETOWN STATE HOMEOPATHIC HOSPITAL.

Being the annual report of the trustees as sent to the Legislature, showing the work done during the past year. A valuable contribution to the statistics of homeopathy.

A HOMEOPATHIC MATERIA MEDICA ON A NEW AND ORIGINAL PLAN. By M. W. VAN DENBURG, A. M., M. D. Sample fascicle contains the arsenicum group.

We have already spoken in strong commendation of Dr. Van Denburgh's work, as shown in the sample fascicle. It comes nearest to the perfect materia medica of any work we have seen. It is full, complete, thorough, comprehensive, and arranged in such a way as to be thoroughly practical and labor saving to the physician, either in making a study of a drug, or in seeking the simillimum. It is a work that every homeopathist not only should but must have.

HAHNEMANN'S DEFENSE OF THE ORGANON OF RATIONAL MEDICINE. Translated by R. E. DUDGEON, M. D. Philadelphia, Boericke & Tafel, 1896.

This little work, which was professedly written by Hahnemann's son in defense of the *Organon of Rational Medicine*, a title, by the way which the opponents of homeopathy have adopted as their own, was undoubtedly written by the father, and reflects his

style and education. The book is interesting reading, even now, as the attacks upon homeopathy are merely a rehash of those made in the time of Hahnemann. It is a forcible presentation of the subject from Hahnemann's standpoint, a little more forcible than we should express it in these days, but neither Hahnemann nor his opponents mince their words, and Hahnemann carries the war into the enemy's camp. The book is noteworthy as being the only defense of his teachings Hahnemann ever put forth.

TRANSACTIONS OF THE SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION. Vol. viii. Published by the Association, 1896.

This is a handsome volume of 300 pages, containing the report of the eighth session of the association, held at Washington, November, 1895. There are a number of papers upon subjects of interest to surgeons and gynecologists, with the discussions thereon.

The Era Publishing Co. of Chicago, announce the following new books :

POCKET-BOOK OF URINARY ANALYSIS. By CLIFFORD MITCHELL, M. D.

MANUAL OF SURGERY. By CHARLES ADAMS, M. D., and H. R. CHISLETT, M. D.

SYSTEMATIC TREATISE ON THE PRACTICE OF MEDICINE. By CH. GATCHELL, M. D.

THE BOOK AND THE BUILDERS is the title of a neat pamphlet issued by the publishers of the Homeopathic Text-Book of Surgery, giving a description of the book, its building, and something of interest concerning the builders.

The Macmillan Co. announce A SYSTEM OF MEDICINE, by many writers, in five volumes, edited by THOMAS CLIFFORD ALLBUTT, M. D.; A SYSTEM OF GYNECOLOGY, in two volumes, edited by T. CLIFFORD ALLBUTT, M. D., and W. S. PLAYFAIR, M. D.

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Materia Medica.

Symphoricarpus Racemosa in nausea and vomiting of pregnancy has often proved an excellent remedy.

Borax in Dentition.—Borax is indicated in painful dentition in commencing teething, where there are much dribbling, fretfulness, and dread of downward motion.

Apis in Ovarian Diseases.—Berl. Zeit.—Dull pains in region of both ovaries, especially on beginning to walk and on bending. Lessened by lying on the right side. Pulsations, bearing-down pains in back, and constant urging to urinate.

Cypripedium in Insomnia of Infants.—This remedy is successful in combating the sudden wide-awakeness sometimes met with in infants or young children, who abruptly awaken after a few hours sleep and remain awake for hours. Nux vomica should also be thought of in this connection, especially when the wakefulness comes on about 2 or 3 A. M.

Picric Acid in Uterine Diseases.—Dr. Dewey, Med. Cent.—This is a useful remedy in peripheral nervous disturbances such as occur as a result of retroflexion of the uterus. There is a feeling of burning and weakness in the lower back. Tearing in the lumbar region. The legs are heavy and weak, with numbness crawling and pains, often, too, frontal headache. In uterine complaints it often may come in as an intercurrent or finishing remedy. There is a general tendency to coldness, especially of the extremities; in fact the whole organism seems in every way below par.

Caulophyllum.—Dr. A. C. Cowperthwaite.—While superficially some of its symptoms seem to correspond with those of belladonna, close investigation reveals the fact that these symptoms have only a superficial resemblance, and that they arise from an exactly opposite condition, namely, atony. The sensation of fullness, congestion, and weight arises from a sluggish circulation through the parts, due to atony. It is often a valuable

remedy in dysmenorrhea where atony is present, but its greatest sphere of usefulness is in chronic metritis, passive hemorrhages, protracted lochia, and other troubles following abortion or confinement, atony being an ever-present and distinct feature.

Cœnanthe Crocata in Epilepsy.—Dr. V. Rappaz (Boletin de Homœopatia) was consulted with regard to a young girl of ten years who suffered for three years from epilepsy, and who, under distinguished allopathic treatment, had steadily grown worse; the seizures gradually increasing in frequency and intensity. The patient was depressed, pale, and without appetite from overdosing with various bromides. April 18 she received *cœnanthe crocata* 6 cent. dil. No attacks until May 12, when a slight seizure occurred. June 3 she had a mild seizure of vertigo, without losing consciousness. The twelfth dil. was then given, and no other attacks appeared. She entirely regained her health.

Cuprum in Pediatrics.—Chorea finds in cuprum its remedy when it is periodical, with irregular movements commencing in fingers and toes; twitching is often confined to one side, and is better when lying; there is often laughter, and grimaces accompanying. In hydrocephalus, acute or chronic, cuprum may be the remedy, especially if it be brought on by a retrocession of an eruption. There will be delirium, convulsions, stiffness of the neck, skin very pale, thirst, cold hands and feet, trismus or tetanus; cannot hold the head up; it comes in better in the stage of exudation. In myelitis, when there are jerking and twitching of the muscles, short oppressed respiration, stiff, lame feeling in back and lumbar region, spasms of extremities, weakness, prostration, and debility, cuprum will be indicated.

Obstetrics.

English Rules for Midwives.—The following rules are in force in the Clifton Dispensary, England:

1. Every midwife must possess a bag, which she must take with her whenever she is called to a woman in labor.

2. The bag must contain, besides other necessities, the following :

A box of antiseptic powders, each consisting of ten grains of corrosive sublimate and a grain of cochineal. The box will be labeled The Antiseptic Powders.—Poison.

A bottle of glycerin, with every two ounces of which a grain of corrosive sublimate has been mixed. The bottle will be labeled The Antiseptic Lubricant.—Poison.

A nailbrush and a piece of soap.

A packet of sanitary wood wool.

A box of twenty-grain iodoform pessaries.

A copy of these rules.

A book of forms for reporting cases to the resident medical officer.

3. The midwife, while she is in attendance on a patient, must wear a clean light-colored cotton dress and a clean white apron.

4. The midwife's nails must be kept short.

5. Before making a vaginal examination the midwife must prepare an antiseptic solution in the following way : One of the antiseptic powders is to be placed in a clean basin, and a pint of hot water is to be poured upon it and stirred with the finger until the powder is completely dissolved. The solution will be of the strength of one part in 1000.

6. Before making an examination or touching the external parts the midwife must wash her hands and wrists with soap and hot water, cleaning her nails with the nailbrush. She must next rinse them free from soap. Then she must hold her hands for a full minute in the antiseptic solution which has been prepared. The hands must not be wiped before making the examination, but the fingers must be anointed with the antiseptic lubricant. No substitute, such as lard or vaseline, is to be used at any time for anointing the fingers.

7. Having made the examination, she should again wash her hands in soap and water.

8. After labor the external parts are to be washed with clean wool which has been soaked in the antiseptic solution.

9. After a case of tedious labor an iodoform pessary is to be inserted into the vagina. A similar pessary is to be used night

and morning for the first three days, and once in twenty-four hours for the next six days.

10. The services of the resident medical officer shall be obtained if the presentation is obscure or unnatural; if the labor is unduly prolonged; if the discharge is excessive or becomes offensive; or if the woman does not appear to be progressing favorably.

11. The midwife must wipe the child's eyelids with a clean napkin as soon as the head is born. This should be done if possible before the eyes have been opened. When washing the child the midwife is to separate the lids and squeeze over the eyes a piece of wool that has been soaked in the antiseptic solution.

12. Ergot is in no case to be given before the birth of the child.

13. Within twelve hours after any confinement the midwife must report the case to the resident medical officer on the form provided for the purpose.

14. The midwife shall visit the patient daily for the first three days after confinement, not reckoning the day of confinement as one.

15. If the midwife has been brought into contact with a case of puerperal fever or any other illness supposed to be infectious, she must immediately report the fact to the resident medical officer, and she is not to proceed to any case of labor or visit any of her patients until she has received his permission to do so. Neglect of this rule will mean instant dismissal.

Vagitus Uterinus.—Dr. Flatau (Centralblatt für Gynäkologie,) reports a case of a quartipara, at the normal end of an uncomplicated pregnancy, in whom the onset of labor was marked by copious hemorrhage. Placenta prævia lateralis was diagnosed, and in the hope that the head would descend and act as a tampon, the membranes were ruptured through the partially dilated os uteri. The anticipated result was not realized, and a tampon of iodoform gauze became necessary. The hemorrhage, however, persisted, and podalic version was performed. With the outer hand grasping the head, an attempt was made with two fingers introduced into the uterus to bring the feet together. In the performance of this act the umbilical cord was compressed and at

once cries were heard. These were repeated when the cord was again compressed. Version was finally effected successfully, and the child at once extracted. The infant was asphyxiated, but was resuscitated by mechanical irritation of the precordium. The explanation offered for the phenomenon observed is, that air was introduced into the uterus with the hand, and that compression of the cord induced dyspnoea, with the resulting cry on the part of the fetus.

The Third Stage of Labor.—Dr. Bufour.—The third stage of labor is the period of greatest anxiety to the accoucheur, and yet it is the stage about which least was known, up till recent years. The accepted view was that separation of the placenta began in the second stage, and that hemorrhage was a factor in its production. A study of uteri removed by Porro's operation led the author to the opinion that separation did not occur till the third stage commenced, that its texture accommodated itself to the shrinking of the uterus, that there was no space in the uterus into which the placenta could bulge, and no evidence in support of retroplacental hemorrhage. These views are now supported by examination of frozen sections from patients that have died during the second and third stages of labor. These sections prove that there is no detachment before the third stage, hence the absence of bleeding—a rational explanation of the arrest of hemorrhage by a retraction of the muscular uterine walls, and compression of the blood vessels prior to the separation of the placenta and its expulsion in the direction of least resistance.

Chinese Methods of Predicting the Sex before Birth.—Dr. J. J. Malignon, Arch. Tocolog. et. Gyn.—A round, prominent abdomen projecting forward so as to interfere with locomotion indicates a girl, while a uterus extending very high upward means a boy. A fresh color of the skin, with only slight pigmentation, especially of the areola and slight change in the features, points toward a girl, the opposite condition to a boy; violent movements of the fetal extremities also indicate a girl. When after the seventh month the right hand of the fetus can be felt moving in the left side of the mother's abdomen—there may be some doubt about the mother's ability to distinguish the right hand

of the fetus from the left—it is male. The most interesting methods cited are two which point to a very high development of the mathematical faculty among the Chinese. The first depends upon the second figure of the mother's age and the probable month of conception. If both figures are odd, or both even, the child will be a boy. If one is odd and the other even, a girl is expected. The most complicated method of all was published in 1593, by the wise man, Fschweng-Fa'wei: To the number 49, evidently a number regarded as sacred, add the number of the month of conception, and from the sum subtract the age of the mother; then subtract 1 (for the heavens), 2 (for the earth), 3 (for mankind), 4 (for time), 5 (for the elements), 6 (for the musical scale), 7 (for the plants). If the remainder is an odd number, the child will be a boy; if even, a girl. If the remainder is larger than the number eight, that number is also subtracted (for the directions of the wind), and the decision made according to the final remainder. Even European residents of China believe in this method.

Rupture of Uterus Overlooked after Labor.—Dr. Doléris Archives de Gynéc. et de Tocol., reports the case of an intemperate, cachectic woman, aged thirty-two, subject to scorbutic gums. There was flooding during labor. As the child was endangered, the obstetric assistant turned; the anterior lip of the cervix appeared at the vulva. The fetus was asphyxiated when extracted, and could not be revived. The mother died a few days later without any abdominal symptoms, but evidently from exhaustion due to the hemorrhage. At the necropsy a rupture was found in the uterus, extending from the neck across the weak zone of the right side of the uterus up to Bandl's ring. The lips of the cervix were thinned, and their tissue degenerate. Doléris draws attention to the fact that the rupture occurred with no prominent symptom; though the patient was sickly, and already exhausted by pain and hemorrhage, there was not even shock.

Care of the Newborn.—Dr. Henry E. Tuley, Atlantic Med. Weekly.

Cord.—The umbilicus is a common source and ready avenue of infection.

After thorough cleansing, a powder of boracic acid and salicylic acid, in equal parts, is applied to the stump upon sterilized absorbent cotton. At each bath the stump is cleansed and the powder reapplied on a fresh piece of cotton; the stump then laid upon the abdomen, and a snug but not tight binder applied to hold it in position. Under this treatment the stump rapidly mummifies, and there is no moist or fungus navel left. At no other time is a binder of any use, and so soon as the cord separates it should be removed. Instead of preventing hernia, the binder is a frequent cause of it merely by mechanically forcing the abdominal contents down into the pelvis, and I have never seen a binder, no matter how scientifically applied, which will stay in position twelve hours without requiring readjusting.

Eyes.—To prevent ophthalmia neonatorum :

As the infection generally occurs during the passage of the child's head through the vagina, and the period of incubation is rarely more than twenty-four hours, the instillation of one or two drops of a two per cent. solution of nitrate of silver into each eye, immediately after birth, will in the great majority of cases prevent this dread trouble.

In 4300 births in the Sloane Maternity Hospital, New York (Mittendorf), the mothers being drawn from every walk of life, not a single case of ophthalmia neonatorum developed, the Cr  d   treatment being used in every case. It was my privilege to be present at two hundred of these births, and the rapidity and ease with which this treatment is carried out recommended it for general adoption. Should an excess of the silver solution be used, a little saline solution will suffice to neutralize it.

Feeding.—Grease the child as soon as born with olive oil or vaseline (not lard, as it is salted), wrap it in a shawl and lay it away for twelve hours, after which it should be bathed, dressed, and nursed. It should be nursed every two hours during the day, from 6 A. M. to 10 P. M., and every four hours during the night.

(Better complete rest from bed-time, about 10 P. M., until morning.)

The child's temperature should be taken for at least a week after birth, twice daily. Should it be getting insufficient

food, it will have an elevation of from one to four degrees of temperature. Usually it occurs on the third or fourth day; the child is perhaps restless and fretful, its mouth is dry and red, and the temperature reaches 102° or 103° . If artificially fed, or nursed, the temperature will fall to normal almost immediately.

If it is fretful, it should not be given sage or saffron teas and other concoctions, but its temperature should be taken, and if above normal, it should be fed artificially until the mother's breasts begin to secrete. The fact of the occurrence of the starvation temperature is very seldom recognized, but a test of it will show how true it is.

Weighing.—Weigh the child weekly during the first six months to note its growth. Weight is lost in the first week, but is regained by the end of the second week. It should thereafter gain at least four ounces weekly, failing in which its nutrition is defective, either because of impaired quality or insufficient quantity of milk, or defective assimilation. Dr. L. Emmett Holt's method of milk testing is recommended.

Mouth.—An important precaution against thrush or sprue is the regular cleansing of the mouth before and after nursing. This is quickly and efficiently done with a cotton swab on the finger, wet with a saturated solution of boracic acid, the natural enemy of the *oidium albicans*. The washing after nursing removes most of the milk left in the mouth, and that before nursing serves the double purpose of protecting the child's mouth and the mother's breasts from infection through a fissured nipple.

Buttocks.—Instructions should be given as to the proper care of the buttocks, for should an erythema intertrigo develop, it is due to the carelessness of the attendant. The acid meconium, if allowed to stay in contact with the delicate skin, soon macerates it, and an intertrigo develops. Regular washings of the buttocks and adjacent parts with clear water and a soft cloth, which should then be dried and powdered with equal parts of boric acid and starch or talcum powder, will generally keep the parts free from trouble. Many cases of intertrigo, when developed, are prolonged by the habit, so prevalent, of using napkins which have been dried before the fire instead of washed.

Prepuce.—Avoid indiscriminate circumcision :

It should be the duty of the attending physicians to reflect the prepuce of all male children, when they are a month old, relieve the corona glandis of the smegma present, anoint it with olive oil or vaseline, and replace the foreskin. This should be repeated two or three times a month by the mother, and the parts cleansed. By this means there will be no pin-hole openings, and no reflex symptoms generally attributable to phimosis.

Tar Paper under Sheet in Childbirth is recommended. It is aseptic and waterproof, and burns readily, is cheap and readily obtained.

The Heart in Its Relation to Pregnancy.—Dr. Hanfield Jones, London Lancet, speaks of heart-failure after delivery, and reaches some fairly definite conclusions, which are as follows :

1. Both by clinical evidence and by logical deduction we are justified in accepting the fact of hypertrophy of the left ventricle occurring in normal pregnancy as proven. In delicate and feebly developed subjects it may sometimes be absent, and in these cases signs and symptoms of cardiac insufficiency are likely to occur.

2. A certain amount of dilatation of all the chambers of the heart does normally occur in pregnancy.

3. Failure of the ventricle has a distinct effect upon the course of pregnancy. In the early months it leads to abortion, and in the later months to premature delivery. Porak confirms this point, and says that "heart troubles have an evident influence on pregnancy, by provoking metrorrhagias, by determining very often abortions or premature delivery, by producing, it may be, placental lesions, and by acting harmfully on the infant, who sometimes dies before its birth, or is born under conditions not favorable to development, and disposing toward premature death."

4. The heart during pregnancy and the puerperium is specially liable to undergo fatty degeneration. This may be due to retrograde changes taking place after delivery, or may depend on the premature setting in of these changes together with an insufficiently oxygenated state of the blood, dependent partly on anæmia and partly on lung disease.

5. The condition of the muscular heart wall is of more importance during pregnancy than the valvular lesion ; many women with valvular lesions pass through their early pregnancies without any sign of heart failure, but as the heart muscle becomes deteriorated by the strain of repeated pregnancies they show increasing evidence of cardiac insufficiency.

6. Of all the forms of valvular lesion, mitral stenosis of a marked degree is the most disastrous ; this is largely due to the extra strain thrown in these cases on the pulmonary circulation and the right heart. The increased arterial tension, the increased volume of blood, and the increased development of the left ventricle, all tend to produce dilatation of the left auricle and the right ventricle. The pulmonary circulation is thus kept continually congested, unless pronounced hypertrophy of the right ventricle takes place. At the close of delivery, when more blood collects in the right side of the heart, the risk is increased and the danger reaches its maximum.

Should Marriage be Permitted when the Woman is the Subject of Chronic Heart Disease?—Dr. Hanfield Jones, London Lancet.—Regarding this, Macdonald says: "Chronic heart disease ought to be looked upon as a grave contra-indication of marriage, more especially if it assumes the form of anything approaching to severe mitral stenosis or serious aortic incompetence. In such cases we ought, if consulted, to dissuade from marriage." On this point the author does not feel inclined to adopt Macdonald's opinion. If we read carefully over the long lists of cases of heart mischief published from time to time, we shall notice (as has been already said) that many of the women had borne several children without any complication, though undoubted cardiac mischief had existed from the time of their first conception. Provided a valvular lesion is well compensated, and the muscular tissue of the heart can be judged to be sound, and provided also that the patient is a young woman in whom processes of repair may reasonably be expected to go on at a healthy rate, there would be no just reason for forbidding her to marry. In every case it would be well, if the patient has not been under medical observation previously, to advise her to remain under medical supervision for the space of six months, or even a year, that an

opinion might be formed whether the disease was quiescent and vascular equilibrium well established, or whether, on the other hand, yielding of the ventricular walls and dilatation of the cavities were slowly advancing. He quite agrees with Macdonald that we ought not to give our sanction to marriage if, in connection with chronic heart disease, there are any serious symptoms of cardiac disturbance present, such as attacks of dyspnoea, breathlessness, palpitation on exertion, hemoptysis, etc.; and this injunction ought to be the more imperative the younger the patient is and the more recent the acute disorder which has given rise to the lesion.

Abortion and Labor in Women with Heart Lesions.—Dr. Hanfield Jones, London Lancet.—Abortion and premature labor often occur spontaneously in cases of failing heart; but the question is frequently asked whether it is good treatment to induce delivery in patients suffering from active heart mischief during pregnancy. The question should rather be put in another form—viz. : Do cases ever exist in which it is justifiable to bring about abortion or premature delivery? To the first form of question we must certainly answer “No,” but to the second we can reply “Yes.” It is true that in a certain number of cases delivery by nature’s efforts alone has led to an immediate improvement in the heart’s symptoms, but it is none the less true that when physicians have induced labor during the latter months, because of a condition of cardiac insufficiency, the result has been generally disastrous. It has been well said that the condition of any patient in whom it is thought a necessary operation, is one of extreme gravity, and the mere fact of interrupting the pregnancy will not stay the cardiac degeneration which is going on. Although the patient may survive the labor, she will probably succumb during the early days of the puerperium. In practice it would seem that artificially induced labor throws more strain on the heart than when the process is originated by nature. Clearly, when the heart has already been exposed to the toil of seven or eight months’ utero-gestation and is showing signs of rapid failure, it is not prudent to suddenly throw upon it the effort of labor. The cases in which we should resort to the induction of premature labor are those in which it seems desirable

at any cost to relieve the diaphragm from the upward pressure of a large abdominal tumor, such as the pregnant uterus.

With regard to abortion in the early months, he thinks the case is different. In many recorded instances of serious cardiac complications, rendering the latter part of pregnancy, labor, and the puerperium a period of continued danger, and resulting too often in death, it is clear that symptoms of commencing failure, such as palpitation, breathlessness on exertion, and malaise, had been noted as early as the third or fourth month. In such a case he fails to see the justification for exposing a failing heart to the strain of pregnancy during the remaining months of utero-gestation, and would advise immediate abortion. The emptying of the pregnant uterus at the fourth month cannot be compared with the strain of labor in the last two months of utero-gestation.

He recommends the same course in a patient who has heart disease, and who has passed through three or four confinements safely; for should she become pregnant again, clinical experience demonstrates that the risk she encounters is vastly increased. No physician would lightly interfere with the course of pregnancy, but it is folly to allow things to take their course when science has taught us that the course is almost certainly laid on the down hill track.

In conducting the labor at full term, the point may be considered as established that the second stage should be made as short as possible, and that forceps or version afford most valuable aid.

Regarding the action of free bleeding during the third stage of labor, he earnestly bears testimony to its useful effect. A free loss tends to relieve the right heart from undue engorgement, and considerably lessens the risks of sudden stoppage of the heart. Equally useful is the application of leeches over the liver or heart during the puerperium, when blueness of the lips and face, with dyspnoea and pulmonary trouble, tell a tale of an over-distended and failing right ventricle.

Of all drugs, strychnine and nitrate of amyl have seemed to the writer to be the most useful. The latter drug, by dilating the arterioles and keeping the blood in the peripheral circulation, gives temporary relief to the failing right ventricle and lessens

the work of the over-burdened heart. The action of the strychnine as a cardiac tonic is too well known to need notice here.

In the New York Medical Journal of January 18, 1896, Rosenberg specifies the earliest symptoms of the disturbed heart's action as dyspnœa, palpitation, œdema of the face and extremities, and bronchitis, and advises the suspension of every exertion on the part of the patient, the recumbent posture being retained during the greater part of the day. Frequent examination of the urine is indispensable. A strict milk diet must follow the finding of the first trace of albumin. As to the advisability of the early administration of cardiac stimulants, writers are not agreed. As we do not hesitate to give these drugs in mitral insufficiency during the non-pregnant state, their administration seems to be all the more indicated when the damaged heart is suddenly called upon to perform an extra amount of work.

In case this mode of treatment is not followed by amelioration of symptoms, and the cardiac incompetency increases in spite of our efforts, the question of the propriety of terminating pregnancy may justly arise. Unfortunately, says the author, the hope is delusive that relief may be given by inducing premature labor. The reports of the majority of such cases are reports of failures, and even if premature delivery has been safely performed and the woman for the time being is improved, her condition is yet one of extreme peril from asystolism. Success can only be expected if the pregnancy is terminated before the onset of serious symptoms.

In the management of labor itself we should endeavor to give the heart the greatest possible working space, and to tone it up for the final effort; to this end the patient should be placed in a half-sitting posture, and alcoholic stimulants, camphor, strychnine, and strophanthus may be given; the nitrites are indicated whenever the pulmonary circulation becomes embarrassed. The main indication is, however, to deliver as soon as possible, on account of the dangerous effect of the pains upon the heart. These operations must be performed under an anæsthetic, because the mental and physical suffering of an operation without anæsthesia may produce the most serious shock to the heart.

Delivery is followed by momentous changes in the circulation.

If one is an adherent of Fritsch's theory, a loss of blood will appear very serious, while according to Spiegelberg, a moderate hemorrhage may be desirable to relieve the embarrassed right heart, which he considers the immediate cause of heart failure. Ternier, Berry Hart, and others report cases in which excellent effects from venesection were observed, and backed up by these authorities, one is justified in trying the treatment. The writer has administered nitro-glycerin with the same object in view. The effects of full doses of nitro-glycerin or amyl nitrite are indetical with those produced by venesection; they lessen the strain upon the heart by dilating the small peripheral vessels throughout the body.

The expulsion of the placenta should not be hurried. The statement has been made that Credé's method is not advisable in these cases, since it is apt to cause too sudden a change in the vascular pressure; manual removal of the placenta has been advised, that detachment might be gradually accomplished, but the prolonged anæsthesia thus necessitated is a serious objection.

During the puerperium the heart demands constant watching, as a large number of cases have ended fatally within a few days or weeks after confinement. Rest, simple diet, and appropriate stimulants form the rational basis of treatment.

Gynecological Etchings.

Ulcus Rotundum Simplex Vaginæ.—Dr. Beuttner, Monats. f. Geburtsk. u. Gynak., describes two instances of this singular disorder in his own experience. The first patient was forty-four; she died of mitral stenosis, with many complications. The ulcer lay on the posterior vaginal wall, an inch below the os uteri. It was over half an inch in diameter. The second patient was fifty-eight, and had also succumbed to valvular disease. In almost the same position the cicatrix of an ulcer of the same type was detected. Zahn described the first case of this disease about twelve years since. The patient was seventy-six, and had died of cardiac

disease with extensive endarteritis. In 1889 he detected another round ulcer in the body of a woman, aged fifty-one, with mitral disease and pulmonary phthisis. In 1894 Braithwaite described two cases (destructive ulceration of the vagina) in living, sickly patients. Browicz's case was fifty-nine, and died of pneumonia; there was widespread atheroma of the arteries, including the uterine. Here thrombosis and obliteration of the vessels immediately around the ulcer were detected. Skowronsky's patient, aged thirty-seven, was sickly, like Braithwaite's. It is noted that this *ulcus rotundum simplex vaginæ* is in no way related to Clarke's *ulcus phagedenicum corrodens*. The round ulcer is not malignant, but clearly a result of malnutrition. Beuttner's second case, where the ulcer was first found after death, yet was then already healed, though the patient had died of a grave chronic visceral disease, proves that general treatment (probably rest in hospital in this instance) can alone effect a cure. Braithwaite's first case was not benefited by local applications.

Treatment of Endometritis.—Fehling.—Wiener Med. Press.—In acute endometritis, it should be distinguished, whether it be of puerperal origin or not. In the former, at the commencement, wash out the vagina antiseptically every two or three hours. When, after twenty-four hours, no improvement is noticed, the uterus is to be disinfected by an injection, and if necessary the same repeated once more after a lapse of twelve or twenty-four hours. The number of uterine injections to be restricted to two, for, if that does not arrest, then the septic process is beyond the endometrium.

Scraping in puerperal endometritis is to be recommended in case of a relapse in the second week or later, or in endometritis after abortion, with evidence of foreign substance.

In acute endometritis, not of puerperal origin, mostly due to gonorrhœic infection, general treatment is to be advised (rest in bed, ice, cathartics, abstinence from coitus, morphine, etc.).

In gonorrhœic endometritis, when the infection is limited to the vagina and cervix, no attempt should be made on intra-uterine medications; which are to be regarded as dangerous as though the appendages had been affected. Active vaginal antiseptic injections is all that is required. In gonorrhœic endometritis without

inflammation of the appendages, the gonococci in the serous membrane can be destroyed by eroding with carbol. chloride of zinc, tincture of iodine, etc.

Chronic endometritis corporis, F. treats in the virgin and multipara, when due to constitutional derangement (anæmia, chlorosis, tuberculosis), with general tonics first, but not locally. Author is opposed to local treatment, even in local infection, when accompanied by acute inflammation of the uterus and appendages, the parametrium and the pelvic peritoneum. First, the inflammation of the appendages should be treated. Intra-uterine treatment should follow dilatation of the uterus (especially by laminaria), with liquid medications (tincture iodine, liquor ferri, etc.), which are introduced by Playfair's probe, or solid medication, such as iodoform, etc. F. discarded the washing out of the uterus, and instead treats chronic catarrh, by filling up the cavity of the uterus partly with gauze and partly with gauze impregnated with iodoform, thymol, etc.

The principal treatment is abrasio mucosa, which is available only in the absence of inflammatory condition of the uterus or its appendages. Simpson's spoon is recommended, and for the inexperienced the elastic spring curette.

In endometritis cervi, F. orders, first, the washing out of the vagina, and then tamponing with cotton, which is impregnated with iodoform, thymol, and zinc chloride. Then aside from the catarrh, hypertrophy of the nerve exists; an excision of the mucous membrane is made after Schweder, or a wedge-shaped incision of the lips, which, as Martin pointed out, helps the involution of the enlarged uterus caused by metritis.

The Vagina and Puerperal Infection.—Dr. Romme, Archives de Gynéc. et de Tocologie, agrees with the newest German school in deprecating routine injections and frequent explorations in normal labors. The results of simplicity have been very encouraging. Walthard had demonstrated, he says, the truth about the vagina and sepsis. The virulence of the vaginal streptococcus in a healthy pregnant subject, not officiously treated by the obstetrician and midwife, is equal to that of the streptococcus of other mucous membranes, such as the alimentary canal, which lives on normal secretions. In other words, it is not virulent at

all, and acts as a saprophyte on healthy tissues. But when the resistance of the tissues is diminished in the vagina, as in the intestine, the streptococcus can act as a parasite, and be as virulent as the special germ, of the same genus, which causes puerperal fever. Hence routine injections are deleterious in normal labor where delivery has not involved true traumatism of the tissues. Digital exploration is to be avoided, as the vaginal streptococcus might be introduced into the previously aseptic but naturally lacerated tissues of the uterus. On the contrary, rigorous disinfection of the vagina is indicated whenever exploration or operative intervention has to be carried above the level of the os externum, and in all abnormal labors. It is also needed when the patient has an affection which diminishes the resistance of the tissues, such as nephritis, cardiac disease without compensatory hypertrophy, syphilis, diabetes, intercurrent infectious maladies, and anæmia.

Prolonged Intra-uterine Retention of an Ovum.—Orloff (Prag. med. Wochnschr., xx, 22,) records the case of a pluripara aged forty-three, who, in November, 1893, five years after the birth of her tenth child, suffered from jaundice and amenorrhea; in February, 1894, from melæna and hematemesis and enlargement of the abdomen; she was tapped three times for ascites, and died on November 9, 1894, from cirrhosis and rupture of a branch of the coronary vein of the stomach near the cardia. In the right horn of the uterus were the remains of a spherical ovum about 2.5 cm. in diameter, consisting of the chorion with many calcified villi; the amnion and embryo had apparently escaped through a tear in the lower part of the ovum, which had no organic connection with the uterine wall. Under the microscope the mucosa showed where the ovum had been attached. Orloff estimated the development of the ovum at from two to three months, that the retention had lasted about a year, and that there had been no uterine hemorrhage.—Resnikow (Centralbl. f. Gynak., xix, 9, 1895) records the following case: A patient who had been twice confined (of twins the last time), when again seven months gravid had a severe illness with fever, during which labor pains came on, but only for a short time. She afterward had a purulent discharge and rigors, followed by amenorrhea. After four

years the uterus was dilated, and the bones of a seven months' fetus removed, and she recovered her health. Two similar cases are quoted.

Arrested Development of Internal Organs.—Dr. Plant, Centralbl. f. Gynäk.—The subject was a girl, aged eighteen, who applied for relief on account of anæmia and total absence of menstruation. Molimen, vicarious hemorrhages, and sexual desire were all absent. The patient was slenderly made and quite a female in external appearances. The hair of the head was long and strong, the breasts well developed; there was no trace of hair in the axillæ; the pelvis was somewhat flat; there was little fat on the mons veneris, and the pubic hair was scanty. The labia majora were very small, and left the nymphæ prominent. The hymen was present; the vagina formed a blind sac a little over half an inch deep. Döderlein and Plant examined the case internally under anæsthesia. The thumb passed into the vagina met the forefinger introduced into the rectum without any obstacle except the septum. On passing the forefinger higher, a fold was detected, crossing the pelvis from right to left just above the blind end of the vagina, the edge feeling like a shoe string. When the forefinger was pressed against the left os pubis, a flattened round body, between a pea and a bean in size, was detected. As far as could be judged in lifetime, the tubes and the right ovary were entirely undeveloped, the uterus hardly indicated, and the left ovary present, but very small.

The Onslaught of Modern Surgery.—Dr. N. Senn.—Charlotte Med. Jour.—The greatest onslaught of modern surgery has been upon the organs of generation, male and female. The future historians who will record the work of many gynecologists belonging to the present generation will have reason to express their surprise at what disasters the art of surgery has produced when plied in cases far in advance of a scientific foundation. Here and there we hear a feeble voice protesting against the indiscriminate surgery upon the organs of generation of the opposite sex, but the mutilating work continues in spite of such opposition and well-meant advice. When we arraign the gynecologists before such a representative body, composed of representative medical men of this

country, for innumerable and inexcusable transgressions of the rules which ought to govern and control the art of surgery, we do not include the scientific, conscientious workers in that department of surgery, but our remarks apply to a class of routine operators which has recently grown to alarming dimensions not only in this, but in nearly every country which has been penetrated by the dim rays of so-called bold surgery. The new generation of doctors finds no longer satisfaction in practicing their profession in some rural district. They have their eyes on large cities and have heard of enticing fees paid to specialists for insignificant operations. Why buy a horse and saddlebags when a fortune awaits them in devoting themselves to a specialty, more particularly gynecology? The recent graduate, or the man who has become disgusted with country practice, seeks a much-employed gynecologist, follows his work for a month or two, and returns to his prospective field of labor a full-fledged specialist. He is now ready to extirpate the uterus, remove ovaries and fallopian tubes, sew imaginary lacerations of the cervix and perineum. Do you suppose that such an aspirant for gynecological fame ever examines a woman and finds her perfect? Is it not true that in nine out of ten cases he finds something to mend?

Laceration of the perineum is a favorite subject of the amateur gynecologist. The extent of laceration and the symptoms caused by it are not always carefully considered in deciding upon the propriety of an operation. The performance of an operation on the perineum in five or seven minutes still serves as an attraction for the lookers-on in many private hospitals and gynecological clinics.

The frequency with which women are being castrated is one of the most flagrant transgressions of the limits of the art of surgery. It is not unusual for one operator to exhibit five or six normal ovaries as the result of half a day's work. All kinds of excuses are made for this kind of surgery. Where is this wholesale unsexing of our female population going to end? The beginning of the end has come. The army of women minus their essential organs of generation is beginning to raise its voice against such mutilating work. The number of women who willingly sacrifice their ovaries to restore their shattered health, without securing the

expected relief, has increased to an alarming extent. This sad experience has made the gynecologists more desperate and bold. It is difficult to say where this rage for the removal of the female sexual organs will end, or what organ will be the next battleground for the aggressive gynecologists. The clitoris, the vagina, the cervix uteri, the ovaries, the fallopian tubes, the uterus and its ligaments, have successively passed through a trying ordeal of operative furor. What the next fad will be is impossible to foretell.

Metrorrhagia in Old Women.—Dr. Monod (Gazette de Gynecology), calls attention to a type of uterine hemorrhage in old women. He cites several cases, among them one twelve years past the menopause. Two were over sixty years old. They had been seized with the copious and prolonged uterine bleeding. The general condition of these women was excellent; no appreciable local lesion was present, neither epithelioma of the neck nor cancer of body, or other intra-uterine growth.

He subjected these women to the use of ergot, with local injections of hot water, curing them all. Uterine hemorrhage is symptomatic, generally of malignant growth, adenomata, and fibroids; although sometimes it is impossible to assign a cause. Bowlet and Trusseau have made a special study of the latter. Free bleeding in chronic endometritis is common in young women. The womb is enlarged, fixed, and painful, and gives issue to a sanguino-purulent discharge. Martin, of Berlin, has observed abundant exterior hemorrhage in tuberculous women without any appreciable lesion of the uterus. He had seen the same in cases of interstitial nephritis and diseases of the heart. Dancel had noted it in the polysarcic. It has been particularly noticed in very corpulent women. Herman and Tourneux have studied the morbid anatomy of this lesion condition. They noted characteristic changes in the uterine tissue. The muscle elements became soft and pliable; the vessels in the mucosum are dilated and brittle; the arteries became rigid and atheromatous. Delbet noted the constant disappearance of the glands in the mucosum and subjacent tissues, they being substituted by a fibrous or fatty tissue. This alteration predisposes in some aged women to excessive uterine hemorrhage.

Treatment.—In most of these cases rest in bed, dilatation of the cervix, curettage, and warm boric acid irrigation suffices.

But in obstinate cases potent astringents are useful. Electricity often serves a most useful part in stimulating the lax muscle and imparting tenacity to the vascular elements.

Pediatrics.

La Perleche.—Pediatrics.—This affection, by no means rare in France, probably exists also in this country, though as yet not reported by one of the titles by which it is recognized elsewhere. Sooner or later, under one title or another, the disorder will certainly be reported in this country; and it is wise for those interested in the affections of children to be prepared to recognize the nature of the disorder, seeing that it is without question transmissible by contact.

The disease named in France *la perlèche*, or more popularly "*bidou*," is known among the Italians as "*male che corre*." It occurs almost exclusively among children, and through them it is occasionally transmitted to adults in attendance within wards and nurseries. The lips are exclusively affected, and as a rule the two lips, upper and lower, the latter, however, predominantly, with a marked tendency to involvement of the commissures. When inspected, the vermilion border and inner and outer folds of the labial surface for a short distance are seen to be covered somewhat irregularly with thin, light-colored crusts and scales, made up in part of macerated epithelium partly elevated from the underlying tissue, exhibiting beneath a reddish, occasionally a decidedly inflamed, surface. At the commissures of the lips there are often fissures and resulting blood-crusts; the latter conspicuous only in aggravated cases. The itching is slight, and the tumefaction rarely extensive. The disease when untreated may last but for a few weeks, or may persist for months. Relapses are not rare.

According to Lemaistre, the disorder is due to a streptococcus occurring in rather long chaplets, and termed streptococcus plicatilis. It is claimed that this micro-organism has been recog-

nized in the water drunk by those affected with the disorder. The question of the contagiousness of the resulting affection is completely settled by its clinical history. By the use of weak ointments of ammoniated mercury, and by painting the lips with solutions of the bichloride of mercury, one part to one thousand, in the tincture of benzoin, the symptoms can usually be promptly relieved.

The interesting feature of this disorder for the clinician is its contagiousness. It is chiefly spread by the use in common of drinking vessels by the infected and the healthy. In the matter of diagnosis, as distinguished from the seborrhœic eczemas of the lips, with which Besnier and Dayon seem disposed to align *la perlèche*, we have never seen the affection complicated with symptoms in other regions of the face, though it is to be remembered that the proof of the parasitic nature of seborrhœic eczema is very strong. With respect to the other eczemas of the lips often encountered in children, especially of the lower classes in society, we have never seen in *la perlèche* the characteristic snout-like deformity produced by projection of the lips when affected with eczema simplex, nor is the itching commonly so annoying in the contagious as in the other affection. One must be careful to exclude also the pustules about the lips, occurring for the most part in young girls with long hair, produced by picking the lips with finger nails charged with staphylococci, often in consequence of the irritation set up in the occipital region by pediculi infesting that part. Fissures of the angles of the mouth in the victims of inherited syphilis are commonly not difficult of determination when the other systemic symptoms present are taken into account. And, lastly, it is needful to recognize, when such are present, the toxic effects produced by application of the lips of the child to certain painted and dyed toys ; as also the mechanical irritations originating with the use of such articles as the penny-whistle and the blow-pipe.

Diagnosis in Pediatrics.—If the skin be cyanosed, it suggests a respiratory cause ; and leaden or earthy tint, especially with great pallor about the upper lip, will frequently be found with gastro-intestinal trouble ; the swarthy (*café au lait*), though pallid, face may put the physician on his guard for syphilis ; in the spasmodic stage of whooping-cough the face becomes

swollen, often ecchymosed, the eyelids puffy, the conjunctiva congested and blood-shot; the sunken, vacant eyes, with dark areola around them, indicate great collapse. The expression of the face will not infrequently indicate even the seat of the disease. Jadelot has pointed out the following lines in the infant face which, by their position, indicate the seat of derangement: The oculo-zygomatic line from the inner canthus of eye downward and outward to the cheek, a little below the malar eminence, pointing to derangement of the brain and nervous system. The nasal line, from the upper part of the ala nasi curving downward around the corner of the mouth; said to be never absent in gastro-intestinal derangement. The labial line, beginning at the angle of the mouth and running downward and outward, generally accompanied by rapidly-moving nares; a fairly trustworthy sign of diseases of the lungs and air-passages. The child's attitude should also engage attention. A healthy infant lies with limbs semiflexed, and, if on his back, inclines one cheek to rest on the pillow. When the limbs and trunk are rigidly stretched out, tetanus is suggested; when unconscious, or in great weakness and prostration, the child will be found lying flaccid on his back, with face to ceiling. If found on his side, curled up and with head retracted, a frown will probably be seen, together with the oculo-zygomatic line, suggesting cerebral irritation, or, if there is opisthotonos, spinal irritation. If there is intolerance of light, as in cerebral irritation, the face will be buried in bed-clothes. In abdominal discomfort or in rickets, the child persistently lies on his face, or even rests on elbows and knees. As regards the cry, some information may also be gained here. Sharp, violent fits of crying, with vigorous movements of the legs, usually indicate colic; the sudden, sharp, single, piercing cry uttered at intervals, while the patient lies in a stupid, drowsy, semi-unconscious state, is but too suggestive of meningitis; while the hoarse grating cry of syphilis is characteristic. In contrast to these, note when the child does not cry, as in profound weakness brought on by diarrhea, and in grave pulmonary affections, where the breath is too precious. Lastly, both suction and deglutition should be noted. Dyspnoea and acute fever cause suction to be performed in short snatches; syphilis also necessitates pauses for breathing. In thrush or ulceration, suction and deglutition are evidently performed with great pain; if the throat be sore, there is frequent cough and noise in deglutition. In great prostration, if the child swallow at all, it is an exceedingly hopeful sign.

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EDITOR, B. F. UNDERWOOD, M. D.,
102 Fulton Street, New York.

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ARRESTED FETAL DEVELOPMENT.

BY

EDWIN J. HOWE, M. D.

IN the "Winter's Tale" Shakspeare has *Camillo* say :
"There is a sickness which puts some of us in distemper; but I cannot name the disease; and it is caught of you that are well." Like poor *Camillo* every physician finds many diseases and pathological conditions which he cannot name, and the origin of which he cannot explain. We have grown familiar with the use of the term freaks as applied to abnormally developed persons, chiefly through museum advertisements and an occasional report in our medical journals; but I do not know of the term ever having been applied to prenatal subjects, and it certainly is just as applicable. In this paper I invite your attention to some fetal freaks.

If the accumulated experiences of obstetricians for a century could be put in a permanent form, it would be sur-

prising to find how often an occurrence one considers unique has happened to others. It is the unexpected that happens, and often the most interesting and instructive cases are known only to the modest and hard-working physicians who observe them. In the estimation of many worthy laymen almost anybody can practice midwifery—and so they can, if no emergency arises; but when it does appear the life or death of the patient will depend upon the obstetrician's skill. Fortunately the large proportion of births are normal, and mothers and children do well.

A study of abnormal fetal development is interesting and something we are all liable to meet at any time. "Forewarned is forearmed." In an interesting address before the Chicago Gynecological Society Dr. John S. Clark, in giving the results of his very large obstetrical experience during fifty years, says: "I have had two cases of encephalic monsters, and two of spina bifida." It is not probable that anyone sees very many such cases. Dr. John C. Fraser of East Weymouth, Mass., has reported a case of a double-headed monster in the *American Journal of Obstetrics*, August, 1890. The bodies were united from the upper part of the sternum to the umbilicus, with a cord common to both. There were four perfectly developed arms and hands, and four legs and feet. Both were males. In this case nature, having undertaken to furnish a pair of twins, compromised by forming a monstrosity not acceptable to the parents. Mr. H. C. Hodges reported to the Obstetrical Society of London an encephalous monster. "The vertebral column appeared to be malformed; the coccyx curved backward, forming a short tail bearing hair on its tough integumental covering." Was this the missing link?

We are all familiar with occasional reports of fetal monsters joined at the sternum, ischium, at lower part of the thoracic walls. Anyone interested in pursuing the general literature of malformations of the fetus will find

Professor J. W. Ballentyne's work, published by Oliver & Boyd of Edinburgh, a most valuable aid.

In this paper I desire to call your attention to a few instructive cases of arrested fetal development in my own practice, and leave you to explain them. Perhaps when we have sufficiently subjugated the X rays we will be able to examine the *fetus in utero*, and learn the cause of much that is now obscure.

1. An American primipara, of scrofulous diathesis, went through the early months of pregnancy quite comfortably, but seemed fearful some imperfection would exist in her child. Quickening occurred at the usual time, after which œdema of the legs became very noticeable and albumin appeared in the urine. About the middle of the fifth month, while lying in bed one night, she cried out with severe pain produced by the quick movement of the fetus; this continued for a moment or two, and suddenly ceasing was never felt again. From this date her abdomen began to decrease in size, and she was soon able to wear a waist she had discarded several weeks before. Her general condition improved, and the œdema left her legs. She became more cheerful and resumed her household duties. At the middle of the seventh month she complained of headache, and a weight in the abdomen, which seemed to be getting lower in the pelvis. Being satisfied of the fetus' death, I watched her closely with a view of bringing on premature delivery, if her condition warranted it. She however improved, and went until the beginning of the eighth month, when from lifting a foot-bath she brought on labor. When the cervix was sufficiently dilated, I was unable to determine the presentation, and invited a professional friend to give me his opinion; but he would not commit himself, in fact he said he could not make out the presentation. A few hours solved the enigma. The fetus was generally well developed; the skin was putrid and peeled off when touched, the umbilical cord was black and

shrunk, and the head was a pathological curiosity. The face and right side of the head were well formed, but the left parietal bone was entirely absent. In trying to make out the presentation, which was a vertex one, the finger ran along the sagittal suture with bone on one side and exposed brain on the other. After the delivery, the presentation seemed very plain. The mother made a good recovery, she has since been confined three times, but has never had a living child. Once the fetus was putrid, another's death was evidently caused by nephritis of the mother, and the third by uræmic convulsions.

2. The next case I wish to report is that of a one-legged fetus. A lady who had been pregnant for four and a half months, without unusual prodroma, was seized with a violent chill, which was followed in two days by a show. No abdominal pains were complained of, only a sense of weight in the pelvis. On examination I found the cervix dilated about the size of a silver half dollar, through which the fetal sac protruded. This was easily removed intact, and on rupturing the sac a small putrid fetus presented itself, which had committed suicide by hanging itself with the cord about its neck. It had only one leg, the integument being perfectly smooth where the other leg should have joined the body, and there was no other leg floating about in the sac.

3. The third case which I will briefly mention must have been foreseen by the author who wrote *Parturiunt montes, nascitur ridiculus mus*. I was called to attend a lady in labor, from whose demonstration much was to be expected. After a good deal of suffering she gave birth to twins, one of which was stillborn, and the other lived about half an hour. Together they weighed two pounds.

4. A headless fetus. A detached fetal head about two inches in diameter, rolling about in a uterus after the body has been delivered, is not a pleasant complication to meet. I have found two other physicians who have had such a

case, and neither seemed at all anxious for a repetition. My case was a miscarriage at the fourth month, a footling presentation. The fetus was very small, and the body was delivered without much trouble. In turning the body forward over the abdomen, and making a traction on the head, with the aid of the finger as a lever, the neck parted like a decayed umbilical cord, and the head remained in *utero*. The ordinary forceps or placental forceps were of no possible use in catching it, and it was only after persistent and hard work with the blunt hook and index finger that I was able to fasten it in my grasp so as to remove it.

Since then I have had an instrument made for me, which I now carry in my obstetric bag, to provide against another emergency of this kind. It is the usual blunt hook, split in two longitudinally, with the blades fastened in the center on a pivot so as to open like a forceps. When closed it is a blunt hook; when introduced behind a foreign body it can be opened as desired, and traction made without the body slipping. The parts of the hook in apposition are roughened, so it makes an excellent placental forceps, and it can be used as a tractor in many cases that will occur to you.

I will not trespass upon your patience at this time to offer any opinion why such cases of arrested development occur. There must be a reason or reasons for them, and he who can solve and remove them will indeed be a public benefactor.

INDUCTION OF PREMATURE LABOR.

BYR. RASMUSSEN ROME, M. D.

I. *Indications.*—When gestation is terminated prior to the two hundred and twentieth day from the last menstruation we term it abortion; when the termination takes place after this period, and before full term, it is named premature labor; when the interruption is brought about by artificial means (not criminal), it is classed induced abortion and induced labor respectively.

The artificial termination of gestation becomes a very interesting subject when one or more of the four principal indications confront us. It is not intended at this time to go into the details of the subject, but to select the more salient facts and present them in as practical a way as possible.

The first of the chief indications is contracted pelvis. Considered in this connection, we are warranted in stating that the induction of premature labor as an elective procedure will replace the more formidable operations of Cæsarean section, symphyseotomy, and embryotomy. The process by which we determine upon the proper time to operate is certainly not a simple one. We must establish three facts: first, the degree of pelvic dystocia; second, the date of conception; third, the relative size of the fetus. To determine the first is usually not a difficult matter, with the pelvimeter at hand. Should the external conjugate measure considerably less than eight inches, the patient had better be anæsthetized and the internal measurements carefully taken, in order to discover the amount of pelvic asymmetry. Having determined this question, the period of gestation must next be ascertained. Just at this point

we must be prepared to allow a latitude of about two weeks in our calculations. By ascertaining the date of her last menstruation and the time of "quickening," together with the length of the *fetus in utero*, we will be able to establish the period of pregnancy with reasonable certainty, in most instances. To compute the length of *fetus in utero*, place the point of one arm of the pelvimeter in the vagina in contact with the presenting part or externally on the anterior surface of the symphysis pubis, and the extremity of the other arm upon the highest point of the fundus uteri; then multiply the number of inches obtained by two, and this will represent the total length of fetus. The third question to be decided is the relative size of the fetus to the pelvic brim, and this is the most uncertain. Place the forefinger in contact with the presenting part, and with the other hand upon the abdomen make firm pressure downward in the line of the pelvic axis. If, after repeated examinations of this kind at varying intervals, we find that the presenting part can no longer, without some difficulty, be made to engage the pelvic brim, the time to induce labor has come. Ahlfeld's experiments established a certain relationship between the length of the *fetus in utero* and the period of gestation; namely, that, from the twenty-fifth to the thirtieth week, the intra-uterine length is between 7 and 8 inches; multiplying this by two gives us a total length of 15 inches.

From the thirtieth to the thirty-fifth week, intra-uterine length between $8\frac{1}{4}$ and $8\frac{3}{4}$ inches; total length 16 to 18 inches. From the thirty-fifth to the thirty-eighth week, intra-uterine length between $8\frac{3}{4}$ and $9\frac{3}{4}$ inches; total length $18\frac{1}{4}$ to $19\frac{1}{2}$ inches. From the thirty-eighth to the fortieth week, or full term, intra-uterine length $9\frac{3}{4}$ to 10 inches; total length 20 inches.

Another factor that is of equal importance is the relative size of the fetal head to the various periods of gestation. Here the measurements of Budin, Stolz, and Fournier will

render us signal service. The biparietal diameter (which is the only one of importance in this connection), at full term, is $3\frac{3}{4}$ inches; at $8\frac{1}{2}$ months, 3.4 inches; at 8 months, 3.2 inches; at $7\frac{1}{2}$ months, 2.96 inches, and at 7 months, 2.75 inches.

Let us make a practical application. Supposing our patient has a pelvis that measures, in the true conjugate diameter, 2.95 inches. From the foregoing measurements the biparietal, at $7\frac{1}{2}$ months, measures 2.96 inches, and we may allow .4 inches for cranial compressibility. We make frequent measurements of our patient, and when the intra-uterine length of the fetus is $8\frac{1}{4}$ inches, other things being equal, the time to induce labor has come.

The second indication is hemorrhage at or after the seventh month of gestation. Here, as in the preceding instance, the course pursued is elective, and the object is to add to the chances of the child unborn, without in any way curtailing those of the mother. Hemorrhage from the uterus, occurring during the latter six or eight weeks of pregnancy, should solicit our watchfulness, since a faulty placental implantation may be expected. The earlier the hemorrhage occurs, the more central the implantation; and since, in the greatest number of cases, the attachment is marginal, the bleeding takes place in the last six weeks. The first hemorrhage is rarely so profuse as to endanger either mother or child. But, unfortunately, it is not a measure of what the second may be. The risk to the child's life increases manifold with each succeeding hemorrhage, and while the dangers to the mother are augmented, they are not in proportion to those of the fetus. The time when the second hemorrhage may occur is just as uncertain as the quantity. The patient may be asleep; she may be quietly performing some household duty; or she may be on the street, away from home. In the light of these facts the consensus of opinion is in favor

of induced labor as soon after the first hemorrhage as would insure the best chances for mother and child.

Persistent albuminuria forms the third indication. Since the urine of patients threatened with eclampsia contains albumin as a rule, we may look upon albuminuria as a forerunner of the convulsions. The child may survive the first attack, but subsequent seizures will as a rule kill the child if it was not expelled by the first. In threatened eclampsia there are two lives at stake, and the question is not so much which life to sacrifice as it is what method shall we pursue in order to save both lives; for, unlike the previous indications, in this instance what is best for the one is safest for the other. If, notwithstanding the recognized treatment, the albuminuria persists undiminished, and frontal headache, epigastric pain supervene, and disturbances of vision make their appearance, we believe induced labor offers the best chances for mother and child.

Diseases of the heart give us the fourth indication. Where the valvular structures are at fault, so that a certain amount of cardiac hypertrophy is necessary to compensate for the extra effort placed upon the heart in overcoming the regurgitation or stenosis,—especially if complicated with chronic bronchitis,—and where this compensatory hypertrophy is not complete, the last six weeks of gestation place a severe strain upon the heart, and the added exertions of labor cause many patients to succumb. The advantage of induced labor is that it transfers the energy which would be expended during the last six weeks of gestation to the actual emergency of labor itself, and because of the immaturity of the child it will meet with less resistance during its expulsion and thereby save some maternal energy. During labor the heart should be re-enforced by strychnine, and, after labor, hemorrhage within controllable limits should be encouraged. Ergot should not be given.

II. *Methods*.—Schultz's method of puncturing the mem-

branes is one of the oldest. The amniotic fluid drains off and uterine contractions will be set up, but at what time is uncertain; from hours to days may elapse. Krouse's method is the introduction of an elastic bougie through the os and cervical canal up between the membranes and the uterine wall. A cotton tampon is placed against the cervix, to hold the bougie *in situ*. Tamponing the vagina is serviceable when hemorrhage calls for treatment. Cohen's method is the intra-uterine injection of sterilized water. Because of some imperfection in the technique, air has entered the uterine sinuses and caused the method to be abandoned. Aspiration of the uterus through the vaginal wall is a method that will rarely be called for. The method of directing a stream of hot or cold water, or hot and cold water alternately, against the cervix is very uncertain in its results, and may cause local congestion and inflammation. The faradic current has been employed successfully—the negative pole to the cervix and the positive to the sacrum. Pelzer's method, consisting of the injection of sterilized glycerin between the membranes and the walls of the uterus, received a great deal of attention and application three years ago. But within the past year reports have been recorded showing this method to be fraught with much danger in some cases.

Dr. Hypes of St. Louis, Mo., has recorded a number of interesting cases in the *American Journal of Obstetrics*, December, 1895. From a study of these cases it appears that the absorption of glycerin by the uterine walls causes renal irritation amounting to acute parenchymatous nephritis, and hemoglobinuria due to the power of glycerin to decompose the red corpuscles. This method is both uncertain and unscientific, compared with the following method: We have called consultation and have elected premature labor. The patient is anæsthetized and placed in the dorsal position on a table. The lower bowel has been emptied by an enema and the bladder with a catheter.

The vagina is douched with a two per cent. solution of creolin or 1-4000 bichloride. A speculum is introduced, and the anterior cervical lip is grasped with a volsellum forceps to steady the parts. The cervical canal is dilated to the size of a finger by means of steel dilators. Narrow strips of iodoform gauze are then firmly packed in the cervical canal up to the internal os. When this has been done the packing is continued around about the vaginal portion of the cervix, so as to compress the cervical ring between the external and internal packing. The speculum and forceps are removed and the patient placed in bed. In from eight to twelve hours the cervix will have become softened in most instances and uterine contractions set up. The gauze is then removed, and if it is necessary to hasten labor, or to re-enforce uterine pains, Barnes' or McLean's bags can be employed. This method of packing with iodoform gauze, as described, brings about cervical dilatation by producing organic softening, which is nature's method of causing the cervical canal to disappear and the os to dilate.

Where immediate delivery is necessary the following procedure has been advanced by Duhrssen, who operated upon thirty-five cases, with no maternal deaths and the loss of only two children. The patient is chloroformed to the surgical degree, and the cervix is dilated to the size of a finger with steel dilators. Digital dilatation is then practiced carefully until the supra-vaginal portion of the cervix is made to disappear; then with a pair of angular scissors two deep lateral incisions and sometimes an anterior and posterior as well are made, extending from the external ring up to the utero-vaginal junction of the fornix. The hand is then introduced, a foot secured, and delivery accomplished. This method, of course, is reserved for emergencies.

CURETTAGE FOR SEPTIC UTERINE INFECTION.*

BY

T. GRISWOLD COMSTOCK, M. D., PH. D.

THE curette in gynecological practice, in the hands of experts, is recognized as a useful instrument. I have had occasion to employ it for the treatment of endometritis, and dysmenorrhea, and my experience has taught me that it is an instrument to be used with caution. Some cases of chronic endometritis and uterine catarrh are not cured with a single curetting—occasionally the operation has to be repeated several times. These facts have been found out after many trials, and they only prove true the adage that “It requires more than one swallow to make a summer.” Therefore, we have come to the conclusion that the curette, although it is a useful instrument, is by no means infallible. Quite recently we had a case of dysmenorrhea in a strong, well-developed young girl, who suffered so much pain during each menstrual period as to sometimes occasion spasms and insensibility. The patient was chloroformed, the womb was well dilated, and then curetted by means of Rhinestaedter’s flushing curette. By the aid of this instrument, we are enabled to douche the cavity of the uterus simultaneously while curetting, and wash away all débris. In the case of this young lady, the next recurrence of the menstrual flow, after the operation, was normal and without pain. As a rule, in our experience, this radical treatment of dysmenorrhea relieves about *seven* out of ten cases. It is claimed that dysmenorrhea has been cured by “mental suggestion,” and a few authentic cures of the kind we find recorded in the medical journals.

* Read before the Missouri Institute of Homeopathy, in St. Louis, April 22, 1896.

If mental suggestion can relieve this trouble, an operation need not be thought of.

One of the first cares of an obstetrician, after delivery has been accomplished, is to direct his efforts so that his patient may not be exposed to anything that might cause septic infection. If he is attending a case of labor, or an abortion, he should see that none of the secundines are left behind, as foci for setting up a septic process within the uterus. An incomplete abortion is a thing to be dreaded by any practitioner, and no one so well as an experienced obstetrict knows and appreciates the danger of such an abnormal condition. The rule in practice, both after a labor and an abortion, that the uterus should be emptied of all secundines, portions of the placenta, and of all clots, is a classical maxim as true now and as important as when it was first enunciated. If the young doctor would ever keep this rule in mind, and practice accordingly, it would be the means of preventing much trouble, and would result in the saving of many lives that are otherwise often sacrificed.

In midwifery practice, we are not so liable to have retention of secundines and clots as in abortions, but whenever and wherever it occurs, it is liable to set up a puerperal process, that may terminate in septic infection, or what is known as puerperal fever. After an abortion, or after a full-term delivery, even if several days have elapsed—should the practitioner have reason to suspect that portions of the afterbirth or secundines are left behind, and symptoms of septic infection have already set in, it is a rule without exception that all such retained matters must be removed. To effect this, we are sometimes necessitated to resort to the sharp curette, and, following it, to douche the endometrium with either sterilized water or an antiseptic solution—say lysol, one per cent., sublimate, 1-5000, or creolin two per cent. as the practitioner shall elect. Regarding the selection of a curette, as a substitute for it we often employ our index finger, but at other times we have found the

finger curette useful—Hoag's curette—which is a little device that is practically an elongation of the index finger.

Expert gynecologists have now about discarded the blunt curette. It was formerly used by timid operators, and the "American Text-book of Gynecology" says: "If a surgeon must use a blunt curette because of the supposed danger attaching to the sharper instrument, it is questionable whether he should do the operation at all." From a clinical standpoint we approve of this suggestion regarding the blunt curette, and we have accordingly discarded it. Some practitioners of our school when treating a case of a puerperal process, where there is evidence of infection from the retention and actual presence of morbid matters within the uterus, often insist in trying the effect of remedial agents, hoping that a favorable turn may take place, as they especially dread any operative proceeding, like curettage. Our internal homeopathic remedies, such as arsenicum, bryonia, baptisia, rhus tox., aconite, veratum viride, mercurius, etc., in such a case will do good, as they may be indicated; but they cannot physically remove infections and septic matters contained within a uterus, which are the sole cause of an existing infectious fever.

In many instances where puerperal patients were suffering from pains, distress, and high temperature, immediately after evacuating the uterus by curettage or otherwise, and douching the cavity so as to free it from retained septic matters and débris, the temperature fell, the pulse became softer, respiration less hurried, and the condition of the patient was one of quiet ease; rest and sleep followed, a favorable turn set in, and convalescence was the result. This is the repeated experience of every skilled accoucheur in midwifery practice.

Those who have had the largest experience in these septic conditions, affecting puerperal patients, well know that antiseptic agents have a very favorable influence in alleviating them and reducing fever.

Before I close this paper, I wish to speak of the importance of the removal of a retained placenta. The retention of a placenta after a labor is something that fortunately happens seldom; but when it does occur, it is the duty of the accoucheur to act promptly. It not unfrequently happens that the delivery of placenta may be delayed for an hour, and then uterine contractions will set in, and the afterbirth be normally expelled. If, however, a delay of over two hours occurs, then the accoucheur should introduce his hand within the uterus, and carefully deliver. If this cannot be readily done, and the obstetrict finds that he has an hour-glass contraction of the uterus, then the patient should be chloroformed, and, with antiseptic precautions, the hand must be introduced into the uterus and the placenta carefully removed.

This paper was written in order to call the attention of my colleagues to the curette. It is most useful in cases of endometritis which have resisted homeopathic and other auxiliary rational treatment. If the endometritis is not complicated with cellulitis, salpingitis, pyosalpinx, ovaritis, septic gonorrhea, or chronic peritonitis, curettage and flushing of the endometrium may be properly undertaken. But as a rule, periuterine inflammation or disease of the appendages contra-indicates the use of the curette. Retained matters from incomplete delivery of the afterbirth in any case of parturition, whether at full term or abortions, where we have hemorrhages, or fetid discharges, indicate the employment of the curette. I have seen a hemorrhage in a young lady, from a small polypus, resist remedies for six weeks, until the young subject was almost exsanguinated, and as soon as the uterus was exposed with the speculum and the polypus brought into view, it was at once removed by a sharp curette, and the patient made a rapid recovery. Another affection is villous and fungoid degenerations of the endometrium, that keep up a

constant and annoying discharge with hemorrhage ; these may be quickly and safely removed by curettage.

In other instances the curette may be required for diagnostic purposes, *e. g.*, where we have abnormal discharges and suspect the existence of malignant disease. Here we curette to examine the product microscopically, so that we may decide whether we have a cancer to deal with. It is, of course, unnecessary to state that curettage, or the introduction of the hand within the uterus, should be always done with the most careful antiseptic precautions. I wish also to make one statement, and that is, after curetting and flushing out the débris, the uterine cavity should be cleaned and dried with sublimated candlewicking, and then the uterus carefully packed with iodoform gauze, which will be expelled within forty-eight to seventy-two hours.

Occasionally a patient cannot endure the packing, and its presence may induce pain and so much disturbance as to require its speedy removal. Such cases must be carefully watched, and if the distress is too great, the packing should be removed and the uterus douched with hot water.

Every case must be individualized and carefully treated in detail. If the pains persist a hypodermic of one-fourth of a grain of morphine may be required.

The operation is a satisfactory one when the above details are all strictly carried out, but if the packing can be left in about two days a good reaction will follow and it gives a better result.

In presenting this paper to the Institute, I am aware that I may have told you nothing new ; but curettage occupies a place in gynecological therapeutics that can be supplemented by nothing else, and my apology for the paper may be best expressed in the aphorism, *Decies repetita placebit*.

CONTINUED FEVERS OF CHILDREN.

BY

ALLISON CLOKEY, M. D.

I WOULD not enter here into a consideration of the fever which is symptomatic, and hence secondary, we might say, to an inflammation in some organ; for example "gastric fever," so called. If there be such a fever, with the lesion in the stomach, we must conclude that the latter is inflamed, in a condition of catarrh, and the pyrexia is only that incident to inflammation anywhere. We would hardly expect a fever symptomatic of inflammation in the stomach to differ in any way from inflammation of the same type in the intestines, for instance. By continued fevers, of either child or adult, I understand that we mean those caused by some miasm, and the title of this paper might, therefore, just as well have been "Typhoid and Remittent Fevers," for these are the fevers which I propose to discuss.

Typhoid and remittent fever play so important a part in the practice of the general practitioner, and every physician who has them to deal with is so familiar with their every phase, that any further consideration of them seems almost superfluous. No attempt, therefore, will be made to treat the subject exhaustively, but only a few observations will be offered which every physician who practices in a malarial locality has doubtlessly made for himself.

I seriously question whether typhoid and remittent fever deserve a place in a work devoted exclusively to diseases of children. As a matter of fact we know that they are much more common among adults, to which I would add that remittent fever is relatively more common in either case. It is a well-known fact that Peyer's patches, which are the seat of the specific lesion of typhoid fever, are undeveloped

during the early years of life, and for this reason we are told it is not until about the fifteenth year that age becomes a predisposing cause of typhoid, the years between fifteen and twenty-five being those in which the disease most frequently occurs.

I would throw out a thought in this connection which has frequently occurred to me in the study of typhoid fever. It is said that "the groups called Peyer's patches are very imperfect (in children)—so much so that they are not liable to disease; and typhoid fever, in which they are invariably inflamed, is extremely rare in children" (Jacobi). Is the inflammation of Peyer's patches the *sine qua non* of typhoid? If not, how does this imperfect development in early life account for the infrequency of typhoid during these years? We understand that typhoid is a specific infection in which the *blood* is the first tissue affected, the lesions in the intestines and elsewhere being secondary to the blood changes. Loomis says: "As soon as the disease is fully established a change in the *blood* occurs. In connection with these blood changes, a series of changes takes place in those organs and tissues of the body in which the process of waste and repair are most rapidly going on." If this be correct, how can the condition of Peyer's patches in the child play any part in his seeming immunity from typhoid fever?

I cannot believe at any rate that typhoid and remittent fever in the child differ in any way from the same diseases in the adult, and in the following pages they will be considered in the abstract without reference to age.

In the study of the peritoneum we are taught as students to trace the two layers, anterior and posterior, together, following them from the under surface of the diaphragm to the upper surface of the liver, around the liver in front and behind, down to the stomach, and around it in front and behind, down in front of the intestines and back again to form the greater omentum, and thence to the transverse

colon, where the two layers part company, the one going up and the other down.

Typhoid and remittent fever follow in many respects so nearly the same clinical course, that it occurs to me that they, like the two layers of the peritoneum, may well be studied together, the points where they differ only serving to emphasize their resemblance throughout the rest of their course.

To the mind of the physician who practices in a malarial locality, almost the first question that presents itself in connection with a case of continued fever is, "Is it typhoid or remittent?" To those who practice in localities free from malaria, where typhoids pursue a typical course, this question may seem an ignorant one. Our text-books draw such easy lines for diagnosis between typhoid and remittent that one should feel almost ashamed to confess that he was not quite certain of his case, especially when he has had it under observation from the beginning.

In malarial climates we see but few typical typhoids, and the possibility of the fever being remittent often makes the diagnosis not only difficult, but sometimes almost impossible. I have myself had cases which I have seen twice daily from start to finish, in which even after convalescence was thoroughly established, I was unable to say positively whether it had been typhoid or remittent. A case in point might be mentioned—that of a lady, for example, whose fever ran four weeks, the temperature curve being characteristic of neither typhoid nor remittent; there was nothing positive about the appearance of the tongue; the condition of the bowels was not suggestive; there was no eruption; no somnolence or delirium; there was but little exhaustion and emaciation. One day I diagnosed the case typhoid, only to change to remittent the next, and after convalescence was established, in the fifth week, I was as uncertain of the diagnosis as at any time during the course of the case. Upon the first departure from a

strictly liquid diet, several days after the temperature had become normal, intestinal hemorrhages occurred, and the patient had a *relapse*. The diagnosis was, alas! finally clear. The Peyer's patches were involved—it was typhoid.

In work at the City Hospital where the cases of continued fever come in usually after they have run a week or longer, it is sometimes with the greatest difficulty that we can diagnose between a mild case of typhoid and a severe case of remittent fever. In such cases we are frequently assisted in clearing up the diagnosis by cautiously feeding the patient a little solid food; a dry cracker, for instance. If the case be typhoid a rise in temperature almost immediately follows, owing to the irritation of the inflamed agminated patches, whereas no exacerbation occurs if it be a case of remittent fever.

It is claimed by some writers that the diagnosis of typhoid cannot be made with positiveness unless there be the typical temperature range, and the eruption. If that be the case, we have but little if any typhoid in the location where the writer lives. We seldom even look for the eruption, nor do we consider a departure from the classical temperature range incompatible with a diagnosis of typhoid. Our typhoids are typho-malaria, in which the typical evening rise of temperature is exaggerated by the malarial complication. In making our diagnosis we must depend upon the general *ensemble* of the case, which is usually characteristic enough for the purpose of differentiation. The dry brown tongue, the tender and tympanitic abdomen, the delirium, the emaciation and prostration carry us away from remittent fever and into typhoid. And yet these features are frequently so indistinct in a mild case of typhoid, and are so frequently present in a severe case of remittent, that it is difficult to make the diagnosis.

However much typhoid and remittent fever may seem to overlap in their general appearance, they are ætiologically and pathologically quite separate and distinct. I have

before me a recent work on pediatrics in which "Infantile Typhoid Fever" and "Infantile Remittent Fever" are mentioned as synonymous. I am not at all in sympathy with this classification. Aside from the fact that I do not consider infantile typhoid and infantile remittent as distinct types, I am certain that ætiology and pathology carry the two fevers away from each other no matter how closely their clinical course and therapeutics may approach.

The treatment of typhoid fever and remittent fever have so much in common that it must be quite a consolation to the physician who is in doubt of his diagnosis. In a doubtful case the patient will of course be placed on a liquid diet, which should be rigidly adhered to as long as any doubt exists.

The therapeutics of the two fevers is definite, and the writer would not go into a tiresome detail of all of the remedies which have stood the test of repeated trials. Every physician has these remedies and their indications at his finger ends. In this article only two remedies will be mentioned, which, from their service in both typhoid and remittent, are absolutely indispensable to the physician who practices where malaria abounds. They are gelsemium and arsenicum.

Gelsemium is one of our very best remedies in the first days of typhoid, especially typho-malaria, and in mild cases is often the only remedy needed throughout; in remittent fever it is the remedy *par excellence*. In hospital practice the writer has learned to place the utmost confidence in gelsemium. After trying other remedies, he has come to the conclusion that no other remedy acts half so well in remittent fever. Other cases, similar in every respect, treated homeopathically with other remedies as they seemed indicated from day to day, did not recover so promptly as those kept on gelsemium throughout. The more nearly the symptoms of a mild case of typhoid approach remittent fever, the better is gelsemium indicated.

In either typhoid or remittent fever, where the intoxication of the system is too profound for gelsemium, as shown by persistency of the fever, or by great exhaustion, *arsenicum* takes the place occupied by the former remedy in the treatment of the milder forms. Persistent temperature, or progressive adynamia, are the indications that should lead to the substitution of arsenicum for gelsemium.

I believe that the pathology of typhoid and remittent fever support the selection of these two remedies. In either case we have an intoxication of the system by a specific infection; the whole system is infected, and then in typhoid fever the specific lesions appear in the intestines, but we do not understand that the course of typhoid is *determined* by the extent of these lesions. In other words, the intestinal changes do not constitute the pathology of typhoid; that is rather the changes in the blood just as in the case of the malarial fevers, remittent or intermittent.

In the gelsemium case of either typhoid or remittent fever the poison spends its force on the circulatory centers, and we have that relaxation without much emaciation, which is common in a mild case of either fever. In the arsenicum case the poison attacks the nerve centers, and we have that intense prostration and emaciation which indicate that the very centers of organic life have been seriously affected. I say that although the ætiology of the two fevers differ, and although there are specific lesions in the one fever and none in the other, yet *the same centers are attacked in very much the same way* by both poisons.

If this reasoning be correct, the two remedies mentioned are as homeopathic to typhoid as to remittent fever. In prescribing upon the pathology of the case we must not be misled by the fact that the ætiologies differ.

AN OBSTETRICAL EXPERIENCE.

BY

A. M. DUFFIELD, M. D.

DURING the vacation preceding my last year in college, while substituting for a physician near Boston, I was called to the following case, which was my first obstetrical experience.

Miss S., aged nineteen, of very spare build and not attractive appearance, declared under oath that she had been waylaid, chloroformed, and impregnated while in that condition.

Her parents believed the statement to be true, she having come home in a dazed and disheveled condition.

I was first called to see her on June 16, 1884, she having passed a bad night.

Severe pains down spine, and low down in back, across hips; also complained of dizziness, with spots before eyes. Had to be rubbed a long time to keep up circulation; said her heart almost stopped beating during the night. Pulse, 62. Extremities warm, body cold and hard to keep warm. Some œdema of ankles. Urine dark and bloody. Gave digitalis 3x every hour for the weak heart action.

June 17. Examined two specimens of urine and found albumin and blood, also phosphates. Slight acid reaction; sp. gr. 1032.

June 17. Went to see her and found her much more comfortable, the heart's action improved very much. Slept well all night. Stopped the digitalis.

June 18. Called about 8 A. M. Found patient resting comparatively easy. Made a digital examination, but could detect nothing wrong. As I was about to leave the house she went into a violent convulsion, turning dark purple,

even to the ends of the fingers and toes. Every muscle in the body was jerking, eyes rolling about with a wild staring expression, becoming bloodshot. The mouth worked convulsively, and bloody foam issued from it in quantities. Her body was so agitated as to forcibly shake the bed, and it required force to keep her body on it. I gave her *veratrum vir.* in three-drop doses (as I had been told to do in case of such an emergency), but it availed nothing, the only relief seemed to be by forcibly massaging the limbs, spitting and deep rubbing, which promoted the circulation.

This state lasted nearly half an hour, when she came to as from a horrible dream, and the moment she recognized those about her she went off into another spasm just as bad.

I sent for assistance, which I received at the hands of a very prominent allopathist and his assistant.

When they arrived she was just recovering from the third attack, and immediately went into another (after opening her eyes and looking about a few seconds). This was over an hour from the first attack, there having been no interval of over a minute between them.

At my suggestion, my consultant applied the long forceps, high up, and delivered the child with my assistance, ether having been administered by the assistant. The doctor insisted on letting the patient lie lengthwise of the bed (which was contrary to my instructions), he getting up on the bed with his knees and delivering her while in that position.

The child was apparently dead, which my consultant claimed to be the case. I tied the cord, however, for sake of practice, and put the supposed corpse aside, and attended to the mother.

The consulting physician kindly adjusted the binder to the mother and took his departure with his assistant, after assuring me that all was right. I thought she was flowing too freely, but he said not, and I supposed that settled it. However, in a short time I looked and thought that there

was too much hemorrhage, and gave ipecac 3x every fifteen minutes, which arrested it a little.

This was about noon. She had been in the eclampsia about two hours before she was delivered, and remained under the influence of the anæsthetic until late in the afternoon.

Shortly after the departure of the other physicians I was startled by a noise from the baby, which had been allowed to lie unattended to since its advent into the world; there was a little blood oozing from her ear, which soon stopped, however.

The baby was soon made to cry vigorously, and is alive now, as far as I am aware.

Previously to delivery, $\frac{1}{8}$ grain of atropine had been given her hypodermically by Dr. G., and I had dilated the os to about the size of a silver half dollar and ruptured the membranes. He had considerable difficulty in applying the forceps, which I thought was due to the position she was in. He removed the placenta and membranes right after delivery was accomplished, and directed that ergot, in teaspoonful doses, be given her, which was done a few times, but with no apparent effect in lessening the hemorrhage mentioned above. I worked hard for several hours kneading the uterus through the abdomen every time it would get soft and begin to flow much, and did not leave her side.

June 19, about 1 A. M., I decided to use extreme measures, which I had to do alone, as the other doctors were nearly two miles distant and it was midnight. After starting the ether again I had to force her father to hold the cone to her face, while I cleaned out the vagina and uterine cavity of a washbasin full of clots and fluid blood.

The examination revealed a badly lacerated cervix, which was torn into strips like fingers, and the perineum was lacerated to the anus. The uterus was in an atonic state and bleeding very freely. After using very hot

water as a douch without avail, I used my fingers to stroke the interior of the uterus, while cold water was poured from a height on the abdomen, but this failed also. Finally I secured a lump of ice and introduced it into the uterine cavity, and stroked it with that inside, while I kneaded and stroked the abdomen with cold water externally; this caused some contraction, and by leaving the ice inside and applying a cold compress to the abdomen under the binder, complete contraction was secured, and the hemorrhage stopped for good. I then gave ergot in twenty-drop doses every three hours, and aconite 1x in water, and arnica in water, one teaspoonful every fifteen minutes alternately.

I remained by her side until morning to see that her uterus kept properly contracted. Did not dare to leave her until 5.30 A. M. Temperature, $99\frac{1}{2}^{\circ}$ at this time. Continued aconite and arnica, and she was very comfortable except for a great deal of soreness. At 5.30 P. M., temperature 101° ; no flow; douched out vagina and ordered cold compress to abdomen; changed bed; passed urine all right. At 11.30 P. M., temperature 99° . Very comfortable.

June 20. Temperature, $100\frac{1}{2}^{\circ}$; pulse, 96. Changed to other side of bed, and allowed her to lie on her side a little while, which rested her, but made her feel dizzy when turned back. Douched out cavity and relieved her considerably. Used carbolyzed calendula douche. Diet consisted of milk, gruel, and broma.

June 21. Temperature, $99\frac{1}{2}^{\circ}$; pulse, 76. Is doing nicely; continued douches, using permanganate of potash in place of carbolic acid. She had considerable trouble from a recurrent retroversion of uterus, but was able to sit up on the tenth day, and made a good recovery.

The physician who assisted me on the first day never called again, but openly congratulated me on the recovery of my patient, as he claimed to have had six cases of puerperal eclampsia, none of which was as bad as mine, and he lost all of them.

A CASE OF UNILATERAL REMOVAL OF THE
UTERINE APPENDAGES, AND ITS SEQUEL.

BY

BY GEORGE BURFORD, M. D.

LATE in 1893, my colleague, Dr. Washington Epps, asked me to see with him a lady who had recently come to England, from one of the towns in "The Rand," in search of health. She had been married three years, and during this time had experienced an almost unbroken course of ill-health. Bad diagnosis and worse treatment had engendered a whole catalogue of pelvic symptoms, with distant reflexes of a pronounced character.

We found our patient attenuated and anæmic, with every obvious sign of neurasthenia. Exercise was tabooed, and even walking upstairs was impracticable, on account of the acute pelvic pain engendered. She rose late and retired early, and usually when dressed was seized with sudden fainting attacks, preceded by acute local spasmodic pain. Examination showed an exceedingly sensitive abdomen, with marked resistance over the right iliac region, and per vaginam there was further disclosed a bulky congested uterus, not, however, displaced, and much resistance of tissues in the right *cul de sac*.

Various local measures were adopted, and careful therapeutic treatment in addition, with but little permanent result; and ultimately the patient was removed to a private nursing home, where diligent rubbing, with local dressings of ichthyol-glycerin, and various internal remedial measures were perseveringly employed, still with no satisfactory issue. Right-sided pain and constant nausea were the leading features in the *tout ensemble*; and neither remedies prescribed for the symptoms, nor on more general grounds, served us in any way. The last medicinal course she had consisted of *actea* and *platina* in succession.

Under the circumstances I advised laparotomy, with discretionary power to deal with whatever condition presented itself. To this the patient, with Dr. Epps' sanction, consented, and the husband, while agreeing with this suggested course, asked for independent opinion ere this final extreme measure was adopted. The lady accordingly saw an eminent specialist, who diagnosed right-sided pyosalpinx, concurred in the necessity for abdominal section, and expressed his perfect willingness to undertake the same himself.

In spite of the blandishments of the eminent specialist, the lady returned to me for operation, which accordingly was undertaken, Dr. Epps being present, in the summer of 1894. I found no pyosalpinx, but two enlarged cystic ovaries, bulky but unadherent, and the right being decidedly the larger. This I at once removed, and there now remained to decide what to do with the left. This was swollen to at least double its ordinary bulk, dotted all over with small cysts, and evidently in the early stage of hypertrophic cirrhosis. Still the pain had been wholly referred to the right side; the patient, further, was scarcely seven and twenty, had been married but a comparatively brief time, and was, finally, ardently desirous of a child. Was the ovary, though actually diseased, still functionally serviceable? and would not the retrogressive changes, after a possible pregnancy, go far to effect its return to the normal? To leave the ovary would be no bar to its removal at any future time should events demand this, while removal inexorably closed the door against any attempt on the part of nature to retrocession, now the *pars major* of the evil had been removed. In some dubiety, I left the remaining ovary intact, and closed the abdomen. The convalescence proceeded apace.

After a few weeks the patient left town for the seaside, and the distressing sense of nausea, with the pain in the right flank, quite disappeared. The wisdom of the decision to leave the left ovary was severely criticised by the occurrence of pain in the left side—a new manifestation; but as

it was never severe, was intermittent, and as the general condition of the patient had considerably improved, I felt justified in assuring her that it would probably ultimately vanish, at the same time hinting that nothing would be so rapidly curative as gestation. Shortly afterwards she returned to South Africa, and though promising to report progress, did not do so, a silence which I construed as an unfavorable comment on the issue of our plan of conservative surgery.

Now for the *dénouement*. In March of the present year I received the gratifying intelligence that the lady had been successfully delivered in Johannesburg, a month previously, of a daughter; and that both mother and babe were doing well. Appended were also some gratifying acknowledgements of the eminently satisfactory issue of the course of treatment, which, not without anxious deliberation, had been adopted by us in England a year and a half previously. That the pregnancy and the delivery should alike have followed a satisfactory course, during residence in Johannesburg in the midst of its recent epoch of history-making, speaks well for the stability of the gestation process.

I have at previous times contented myself in certain cases with unilateral removal of diseased appendages, with uniformly unsatisfactory results, and in this respect my experience had been exactly that of Mr. Lawson Tait, who emphatically condemns, in marked chronic disease of the appendages, this form of operation. In this particular case this limited plan served us well, and the result is particularly striking as indicative of two important facts: First, no normal pregnancy occurred until after the removal of the inhibitory influence engendered by the gross disease of the right ovary. Second, the left ovary, directly the main disturbances in the nexus of reproductive processes was removed, became functionally adequate to its share in the cycle of gestation; an adequacy which, during the co-existence of the right and more considerably diseased ovary, was lacking. Both Dr. Washington Epps and myself had awaited, not without some misgiving, the issue of our plan of operation; and this issue clearly shows the necessity of discrimination, founded on personal experience, in each individual case.

TWO CASES OF IMPRISONED CLITORIS.

BY

EDWIN M. HALE, M. D.

THE medical profession has for many years been aware of the profound influence for evil caused by abnormal conditions of the male prepuce.

They have caused chorea, convulsions, enuresis, masturbation, malnutrition, dementia, insanity, and idiocy.

Malformations of the female prepuce, the hood which projects over the clitoris, is equally capable of causing all the above morbid affections in women.

I have selected, out of the many which have come under my observation, two cases of an unusual character—cases which must be very rare. Cases are frequent when the prepuce is too long, or too tight, causing compression of the clitoris and allowing an accumulation of irritating smegma around that organ; but, in the two cases I shall narrate, the clitoris was completely imprisoned by the formation of inflammatory adhesions.

CASE I. A married woman about thirty years of age. Several weeks after the birth of her third child, she was attacked with a violent vulvitis, which I suspected was of gonorrheal origin, but did not verify it. In two weeks she apparently recovered from the local disease.

Soon after her recovery she began to act strangely; became insanely jealous of her husband, and showed a great animosity toward his family. Until this time she had been an affectionate wife, and lived on excellent terms with her family. She grew morose, ill-tempered, and unwomanly. Her marital relations were peculiar. She became lascivious, yet experienced no orgasm, and upbraided her husband with impotence, because of this defect.

She grew pale and emaciated, could not sleep owing to voluptuous dreams, and her appetite was variable and capricious. Naturally she was an excellent woman as a wife, mother, and daughter; with an unusual amount of good sense, education, and intelligence.

I came to the conclusion that there must be some unusual disease of the sexual organs, and urged an examination. I found no ovarian, uterine, or other trouble, except a slight laceration of the cervix, which occurred during labor with her first child. But, on examining the clitoris, I found it completely hidden, imprisoned by a growth which resulted from the vulvitis, extending to the prepuce. Pressing on the location of the clitoris, it could be felt under the overlying tissues. It could be rolled under the finger, when it would become erected, with voluptuous feelings. I represented to her that this imprisoned condition was the cause of her ill health, and advised an operation, which was readily consented to.

On opening the thick overlying tissue the clitoris was found bound by adhesions to the hood anteriorly, and to the underlying tissues posteriorly. A large mass of hard smegma had formed around it.

The details of the operation need not be given, except that the two edges of the enlarged hood were pared off, and drawn back, to prevent closure.

She made a good recovery, and a rapid improvement in all her nervous and mental symptoms soon set in. In a few weeks she had returned to her normal state.

CASE II. A young girl aged fourteen. I had been her medical attendant from her birth. When a few months old she had a severe attack of vulvitis, with profuse mucopurulent leucorrhœa. This was most obstinate, and resisted for several weeks internal medicines—such as calcarea, erigeron, mercurius, and sepia; with topical applications of borax, calendula, and other mild remedies. (Now, I treat such cases with a two per cent. solution of argenti nit.

in the beginning, and later on with geranium, hydrastis (five per cent.), copaiva, or oil of sandal wood, two per cent., injected into the vagina.)

She was a delicate child all through teething, had swelling of the cervical glands, hordeolum, and small tumors in the eyelids.

At the age of four her mother discovered that she masturbated. Involuntary masturbation is common in children, even at that tender age, if the clitoris is in an abnormal condition; otherwise I believe it rarely occurs.

The orgasm was produced by rubbing the thighs together. During this proceeding the child's face would flush, the eyes become suffused, and the whole body agitated. This was followed by general relaxation, sighing, and often crying. Various methods were adopted, mechanical and others, to break up the habit, but it was only at the age of seven or eight that it was controlled. At the age of nine choreic movements showed themselves. An examination of the heart at that time revealed no abnormal sounds, but a peculiar irregularity of rhythm, such as occurs in cardiac chorea. Cimifuga and spigelia usually controlled the attacks, which recurred several times a year. At the age of eleven, an unusually severe attack of chorea was followed by inflammatory rheumatism, with endocarditis, and vegetations on the mitral valve. When the inflammatory symptoms were most severe, the choreic movements disappeared. I believe there is generally a relationship of chorea with rheumatism, although in this case, as will be seen, the chorea was doubtless at times excited by the irritated condition of the clitoris.

After the acute symptoms of rheumatism had subsided, the heart was found somewhat enlarged, with mitral stenosis. The next winter another attack of rheumatism occurred, which still further damaged the heart. On her recovery, it was observed that chronic movements occurred

about the 1st of each month, often with epistaxis, great nervousness, weeping, and other hysterical manifestations.

At this time I informed the mother that I believed there was some abnormal condition of the clitoris, and urged an examination. She declined to allow me to do so, but called in a woman physician who declared that the clitoris was perfect. A trained nurse who was in attendance confirmed her opinion.

However, I was so sure of my diagnosis that I insisted on a personal examination, which was finally permitted.

It revealed a condition almost exactly like Case I. The clitoris was entirely imprisoned, and could be felt and rolled under the finger, with some erection on pressure. Two small white points directly over the clitoris attracted my attention. A fine probe could be introduced into them, and into a caseous collection.

Under an anæsthetic (A. E. C. mixture) the clitoris was liberated, the smegma removed, and another imprisonment guarded against. She rallied well after the operation, notwithstanding the cardiac weakness.

From this date all her symptoms improved rapidly. One month from the operation she had slight menstrual pains, but no flow. Two months after, the menses appeared without pain, and in normal quantity.

The parents and others all agree that a remarkable change has taken place since the operation. She has rapidly changed from a child to a woman. Had this operation been delayed, there is no knowing how long the functions of the ovaries and uterus would have remained undeveloped. It is possible that confirmed hysteria or insanity might have claimed the patient.

APPLICATION OF THE FORCEPS.*

TRANSLATED BY

B. F. UNDERWOOD, M. D.

(Continued from p. 271, May, 1896.)

APPLYING THE FORCEPS.

THE first, left, pivoted, blade—guided by the right, held in the left hand.

Introduction of the guiding hand.—The hand which is to serve as the guide—in this case, as the left, the posterior, blade is the one to be introduced, the right hand—is to be passed completely within the vulva. The hand, as has been heretofore taught, is to be pressed cautiously through the vulva, and carried flat, palm upward, directly backward, in order to reach the ear, posteriorly placed, and to cover the parieto-malar line.

Passed in front of the coccyx, which extends on each side, the fingers, in close contact with the head, glide upward in front of the sacrum. (Fig. 36.)

Fig. 36.—Vertex at the inferior strait in left occipito-transverse position. Introduction of the first guiding hand, the right, including the thumb, flat, directly backward, and the presentation of the first, the left, blade. That the blade may enter directly upon the posterior median line the handle should be lowered exactly in the line shown by the arrow.

When the entire hand, including the thumb, has been introduced, and the vulva surrounds the wrist, the fingers will have passed the uterine border, and the ear, the lobule of which is scarcely to the height of the malar bone, which should be embraced in the fenestrum of the blade, should be easily found and felt.

* From the French of Professor Farabeuf and Dr. Varnier,

When the index finger is upon the ear, the other fingers will cover the parieto-malar line, upon which the forceps are to be applied.

Presentation, introduction, and placing of the blade.—
When the right hand is properly placed, the blade is to be

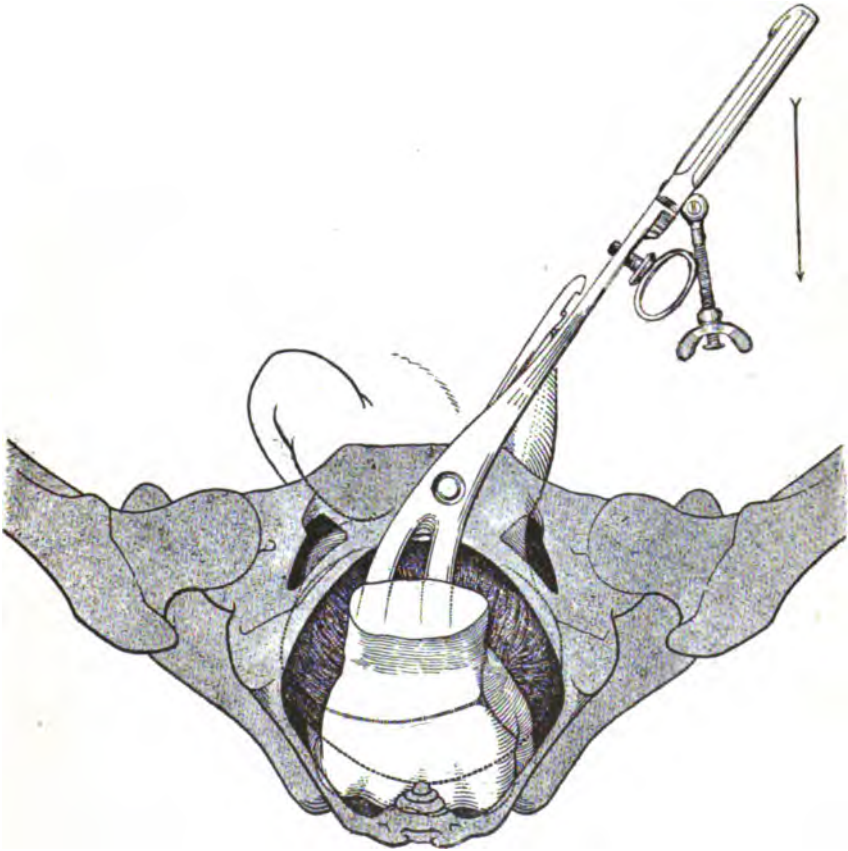


FIG. 36.

presented and introduced. That it may enter in the same axis, and flat, like the hand, the handle must be held at first, very obliquely, turned toward the left side of the

mother. (Figs. 36 and 37.) Then brought directly downward, the left hand, which holds it, descending outside of the right fore-arm.

Fig. 37.—Vertex at the inferior strait in left occipito-

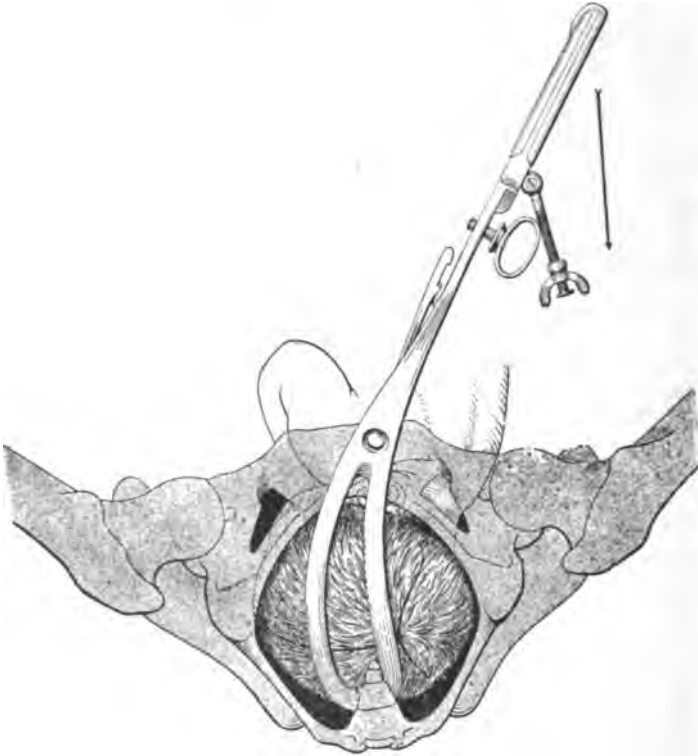


FIG. 37.

transverse position. Direction of the handle and position of the blade at the moment of presentation.

When the blade has been properly applied, the guiding hand is to be removed and the left blade left lying upon the fourchette.

Fig. 38, shows the result of the first step of the applica-

tion. The handle of the left blade when properly placed is slightly raised, nearly horizontal, strongly deflected to the left of the mother; the hook, which is at right angles to the taking surface of the blade, is directed perpendicularly upward, guide to the position of the blade.

An assistant, kneeling at the left, holds the blades in position during the introduction of the second guiding hand and the introduction and placing of the second blade.

The second; right, notched, blade—guided by the left hand, held in the right.

Introduction of the guiding hand.—For the second blade, the right, the left hand becomes the guide.

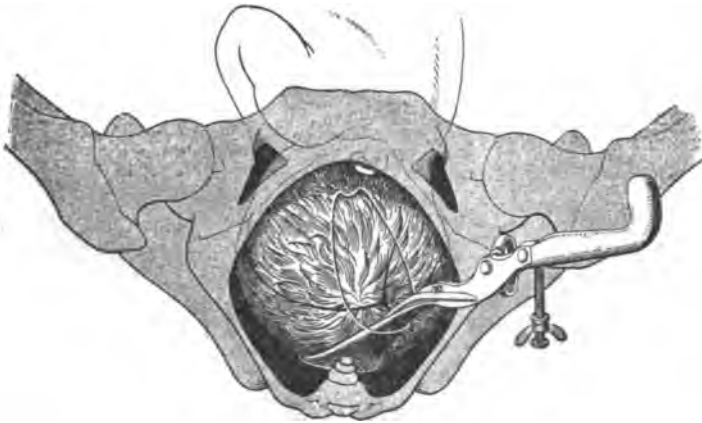


FIG. 38.

This, without the thumb, is introduced until it comes in contact with the head, backward and to the right, between the coccyx and the ischium, as deeply as possible; until its progress is arrested by the contact of the commissure of the thumb with the ischi-pubic symphysis (fig. 39); thus surely passing the neck of the uterus, which should be sought for and found.

Fig. 38.—Vertex at the inferior strait, left occipital trans-

verse position. The first blade in place directly backward, upon the parieto-malar line. The handle under the left thigh, hook directed upward.

Presentation, introduction, and placing of the second blade.—Upon the left guiding hand, properly placed, the



FIG. 39.

right blade is to be placed and carried along its axis. The hand which holds the handle, at first upright, a little to the left of the median plane, being lowered obliquely so that it falls outside of the left forearm. The blade is to be

carried—without hesitation and without force, be it understood—high up. It is necessary that the beak should pass back of the posterior half of the forehead, finding beyond it a space where it may remain, and which will allow of the concavity of the blade adapting itself easily and perfectly to the curvature of the head. Without this condition, the blade would not be able to glide finally, in contact with the head, upon the anterior parieto-malar line, on account of the narrowness of the space between the head and the pelvis.

In producing the gliding motion necessary to bring the blade from the oblique posterior to the direct anterior position, care must be taken to avoid displacing the head and the posterior blade, which will follow if the guiding hand is used to assist the blade. The movement is to be developed and carried out through the handle alone, as has been shown in the directions for placing the blade in the occipito-pubic position. After the blade has been introduced, the handle, which has been brought from above and to the left of the mother, following the line indicated by the arrow (fig. 40), is still raised above the horizontal, a little to the right of the mother; the hook turned always obliquely, upward and to the left, like the taking surface of the blade.

Simultaneously, the handle is to be lowered, for the beak must enter still farther; carried backward toward the left thigh, as the forehead will throw the blade to the right; finally turned, and the hook, which is directed obliquely, brought to point directly to the left of the mother, which will cause the blade, in gliding forward, to move in the manner of a loop. The movement is now one-third made: the blade has passed beyond the guiding hand and is upon the side of the head. While the guiding hand is being withdrawn the lowering of the handle is to be continued so that the beak will continue to rise; the hook turned to cause the blade to glide forward upon the anterior frontal

eminence, until the hook is directed obliquely and to the left. When this has been done the handle will cross some distance above and to the left of the blade first placed. The movement must be continued as it is only two-thirds completed. The handle is to be brought down still more, for the beak must continue to rise, and the hook twisted to cause the blade to glide always forward upon the parietomalar line: only when the hook points directly downward is the movement completed. The handle, crossing more fully that first placed, is finally brought down to articulate with its mate.

It is to be remembered that, in this case, the spiral penetrating movement described by the blade in the pelvis, between the head and the uterine wall, is in three times 45° . When this movement has been two-thirds made, when the blade has passed the posterior half of the forehead, freeing the root of the nose and taking the external anterior orbital apophysis in its fenestrum, the instrument, momentarily twisted to the strait between the head and the pubis, finds some difficulty in advancing further. To overcome this, the handle is to be forced downward when the hook will, almost of itself, turn directly downward, certain indication that the blade is passing directly forward.

Novices never lower the handle of the forceps sufficiently: they hesitate upon seeing a part of the handle pass into and disappear within the genital organs. In this case, the blade, arrested upon the anterior frontal eminence, its beak upon the eye which it menaces, or upon the external orbital apophysis, in either position is badly placed. The application of the articulating surfaces of the blades in either case is impossible, and if the blades are united it is only by displacement of the posterior blade, which is forced from its proper position, recoiling toward the occipitoparietal region; the taking becomes irregular, oblique, and the extraction of the head is awkward and constrained.

Fig. 40. Vertex at the inferior strait in left occipital

transverse position. Placing of the second blade: the blade has penetrated in the space *P*, at the same time that the hook has descended in the line indicated by the arrow *a*: then the handle having turned according to the line of torsion and of motion *t*, the blade at first gliding upon the side of the forehead (the white forceps having the hook transverse). At the end of the movement, the blade is

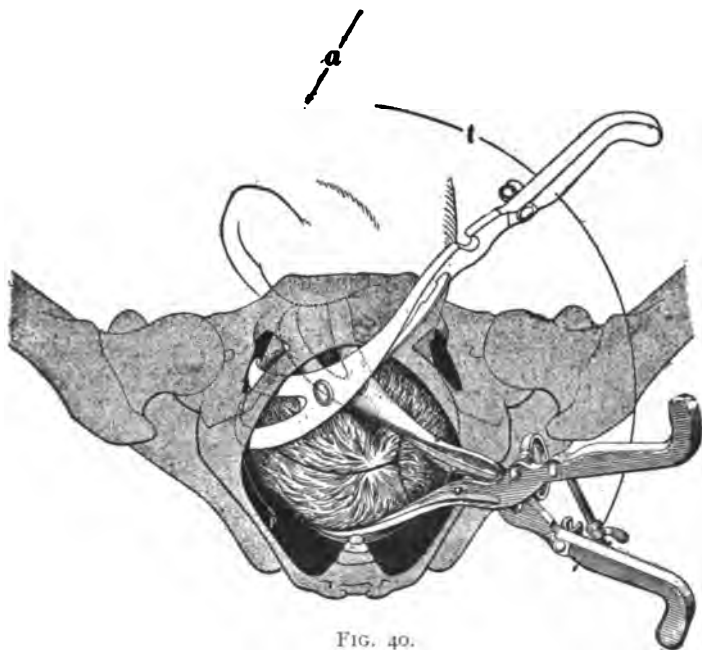


FIG. 40.

brought forward, upon the line of good seizure, the notch below and outside of the pivot.

Articulation of the blades.—When the right blade is thus brought again in front and applied to the pivoted blade it will be noticed that it is more deeply entered than the first. It is therefore to be slightly withdrawn to bring its articulating surface to the level of the left branch, which has been rigidly maintained in position.

If the position of the blades is correct, properly applied, the articulating surfaces will apply exactly. If the contrary is the case, rather than make an oblique and forcible articulation, the blade last applied should be withdrawn by a reverse movement to that of its introduction. If there is the least doubt upon the subject of its position the blade first placed should also be withdrawn and a new diagnosis of the position of the head carefully made and the application begun again.

VERIFICATION.

The articulation having been made, the direction of the handles should be noticed ; if the position is correct, they will be to the left of the median plane (plane of the meridian in which is found the axis of the blades), near to the left thigh, the hooks being in position, the one upright, the other pendent.

The position is correct and should not be modified.

The vertical direction of the hooks indicates that rotation of the head has not been made. The truth of this may be ascertained by touching the head to the right of the forceps when the sagittal suture, running directly transverse, may be felt ; the posterior fontanelle to the left. The nearer this is to the center, the more perfect is the flexion of the head.

The position of the handles being what they should be according to the position of the head, it is proof that the application is correctly made.

DYSMENORRHEA.

BY

C. G. WILSON, M. D.

VERY few women, comparatively, have absolutely no pain or discomfort while menstruating; very few, also, but who can by proper care and treatment secure relief. The means are as various as are the causes of dysmenorrhea. Many times no cause can be found, no pathology or pathological anatomy. But it is there somewhere in the patient, and the cause should be found and removed before any prescription is made, unless the prescription is to assist in its removal. Hahnemann's *Tolle Causam*—remove the cause—is the basis of not only all homeopathic treatment, but all other rational treatment. There are no specifics for dysmenorrhea, because no one remedy will remove all causes of the trouble. Sometimes a fit of anger, sometimes disappointment, sometimes—and the most severe attack I have seen was from this cause—the nervous, self-willed wife cannot have her way in managing domestic affairs. “But,” said this one, “when he sees how I suffer, and the doctor's bills he has to pay, he always gives in.” This may be called the hysterical form. There was no malingering, for the cramps, cold perspiration, and choleraic symptoms were very real and severe. Sometimes polypi or fibroids or congested and irritable ovaries—*any* deviation from normal—will cause abnormal sensations.

What is of practical importance to us is to find what will relieve most speedily and easily, and cure most certainly and pleasantly, our confiding patients.

If called while patient is suffering, it is often impossible to obtain sufficient data to prescribe correctly and homeopathically. If the patient seems chilly, is tearful, golden-

haired, flowing scantily, can't bear the windows closed, must have fresh air—pulsatilla every fifteen minutes, in hot water, will relieve as speedily as an opiate.

If she is cross, fretful, wants to know why you stand there, "why don't you do something," is flowing freely, aching down hips and thighs—chamomilla 30x will give you a rest and her comparative comfort. If she is doubled up, pressing her abdomen with hands or lying flatly on stomach on a hot-water bottle or bag—mag. phos. 3x will give quick and grateful relief. This prescription has given me much better results than colocynth, except in some bowel troubles. This prescription, in fact nearly all remedies in this condition, are to be given frequently in half glass hot water, so hot it can only be sipped.

Should she be unconscious, eyes set, gritting of teeth, and history of flowing stopped or lessened, lachesis has done me most good, though glonoin is a great equalizer of cerebral circulation.

When the pains are hard, pressing down, steady pains—bell. 1x and gels. tinct. have done as well as any, though these pains are hardest for me to relieve entirely. Bell. 1x when face is flushed bright red, throat dry, and throbbing headache; gels. tinct. less excitement with general dull aching in all bones and muscles.

If anyone asks what to do "when the indicated remedy fails," I say, the *indicated* remedy never fails. If it did it would not be *the indicated remedy*; but you failed to give or find the right thing. The *indicated* remedy *always* relieves, but it is not possible for mortal men to always know what that remedy is. What *seems* indicated is a different thing. Everyone always gives that, and often fails. Sometimes the indications may mean hot applications, hot vaginal or rectal injections, which, by the way, are much more often very useful than they are used. Possibly the need is removal of polypus or fibroid tumors; may be marriage is the desire of the sexual system. If mar-

riage is prescribed and taken, and the dysmenorrhea continue, a few well-chosen potencies of pulsatilla will stop the dysmenorrhea, for nine months at least.

A safe remedy of late years is acetanilid, or phenacetin, or similar remedy. When given with equal quantity or more of soda in 3-5-grain doses every half hour, relief is obtained and the nervous system quieted. Usually three or four hours' sleep is obtained before the reappearing pains require a renewal of the treatment. Usually considerable prostration and weakness follow any continued use of this remedy, and it is recommended only in case one can do no better. It is the duty of the physician to do the best he can under all circumstances. And while the homeopathically indicated remedy always is best, there may be cases of suffering for relief of which the homeopathically indicated remedy has not been found or proved. Then one must use other means, and the least harmful are the best for all concerned.

If patient has been relieved during this time, good; if not, it is bad, but probably no worse than she has often been before, and the more easily you can enforce your point that inter-menstrual treatment must be given.

Unless one is limited in time by condition or surroundings of the patient, a thorough treatment with remedies should be given, because most causes of dysmenorrhea can be relieved by them.

Direct patient to live as natural a life as possible. No coffee, tea, stimulants, tonics, laxatives, mineral water. "Nothing," except plain food, pure water, early hours, plenty of sleep, and no dissipation. Plenty of exercise in open air. Perhaps physical culture under care of the physician, the patient taking only such exercises as will conduce to her health, without regard to what she may like or the instructor wish to give. Much harm is done by indiscriminate over exercise. As much need has a physician of Corbett's training as a woman for all the Delsarte exercises.

Pulsatilla will be found indicated in persons of auburn hair, even though they have dark eyes and nux disposition, provided they have the aversion to pork, fats, warm rooms, and summer, with desire for open air and pickles. Also whether menses be profuse or scanty, early or delayed. There is usually delay in getting asleep after retiring, and awakening tired and with bad taste in mouth and offensive breath.

Calcarea is the opposite of *puls.* in some ways. "Fair, fat, and flabby," desire for summer and dislike for cold and damp weather and winter. The feet have cold perspiration in winter, though often no perspiration in summer. Menses too early and profuse. Usually three weeks from beginning of one menstruation to commencement of next. Easily tired, especially ascending hill or stairs. Often out of breath and dizzy then. Usually has catarrhs with profuse bland leucorrhœa. Always better when constipated because loose actions weakens so much. *Calc. iodid 2x* has been of great benefit in fibroids in patient with *calc.* symptoms. It lessens the size, flow, and sensitiveness.

Crocus; menses profuse, long lasting like *calc.*, but unlike *calc.*, dark and clotted, even stringy. Nearly always present is the characteristic symptom of movements as of a child in abdomen, especially at menstrual period or before.

Actea racemosa: headache from nape to vertex. Aching back and down thighs; sharp pains under left breast, increased often by pressure over the left ovary, showing its intimate connection.

Nat. mur. 30x once relieved and cured a severe case for me which had only been controlled by morphine given by an allopath, and which had many symptoms of biliary calculus. There were very severe paroxysmal pains over the gall duct, causing the patient to toss in agony for hours at a time. Vomiting frequent, but there was not a trace of jaundice. After several attacks with intervening anti-gallstone treatment, the patient very much worn out and

despondent, the periodicity of the attacks struck me as significant. On closer questioning she said on one occasion the pains had begun and remained on the left of the stomach under the ribs, and wanted to know if it were possible she had two galls cysts and ducts. Then leaving text-book prescriptions aside, I took the case *à la Hahnemann*, found natrum clearly the homeopathically indicated remedy, and she found relief from the monthly discomfort forthwith. It was evidently a reflex neuralgia, but the pints of olive oil and her industrious searches in the evacuations for calculi were for naught.

Lachesis readily benefits cases with regular scanty flow, with pain ceasing when flow becomes free. Always attended with pulsatilla, like aversion to warm and close quarters, but has thirst and hot flushes with perspiration and smothering spells, chiefly at night and at menstrual times.

Viburnum op. is curative, as well as a ready relief in many cases of cramps with nausea and attended with profuse flowing. It should be continued some months.

These remedies are not from text-books for this occasion, but are the ones it has fallen to my lot to use in curing dysmenorrhea. Many others have been used necessarily, but I do not recall any failures among these where the indications mentioned have been prominent.

ENURESIS.*

BY

DR. GEO. F. DUNHAM.

THERE are three forms of this trying infirmity: one infrequent in which there is almost constant dribbling of urine; a second intermittent type, occurring night and day, in which the child is unable to resist or await emptying of the bladder; and third—the most frequent and most tractable form—occurring only at night.

Its ætiology is somewhat varied, but there lurks in all cases some inherent enfeeblement, as anæmia, tuberculosis, or some neurosis or displacement at the neck of the bladder.

Lithosis or some inflammatory conditions of adjacent organs are often present. Whatever the cause, there is generally brought about an imperfect innervation of the bladder sphincter. Sex appears to exert no influence on the pathological condition.

Many mothers, I regret to say, look upon this weakness only as a matter of great annoyance, and the unfortunate child is frequently punished, whereas, by placing the child under the care of a competent physician while the disease is still in its infancy, the evil might be speedily eradicated. In cases where the disease is hereditary, such as occur where several children of one family are affected, it will be more difficult to afford relief, but it is in such cases the superiority of homeopathic treatment manifests itself.

Many persons console themselves with the hope that the difficulty will be overcome as the child grows older, either at the period of second dentition or at puberty; but as

* Read before the Homeopathic Medical Society of Illinois, May 14, 1896.

this is doubtful, all available means should be adopted to remove the trouble and not rely upon future possibilities.

Parents should be instructed, however, that this trouble cannot be cured in a day, a week, or even a month, but that it requires long, patient effort, and there are times during dentition or illness that all our efforts seem in vain; but a careful selection and administration of the proper remedy for each individual case, together with such hygienic instructions as is necessary, and all will end well. It would be out of place in this short paper for me to enumerate a long list of remedies and undertake to give you their indications. Neither do I propose to laud the specific virtues of any particular drug as a cure-all. Instead, I would urge upon all a more thorough study of the materia medica and its careful application in this, as well as other diseases. In this disease, as well as many others, we occasionally find mechanical causes which require mechanical treatment, but they are not numerous. The less we have to do with empiric methods, the closer we follow in the line marked out by Hahnemann, the better and more successful will be our work. I forbear to enumerate the fifty or more remedies recommended for constitutional treatment, and will confine myself to the few that have been the means of ridding our patients of this trying infirmity.

Belladonna is unqualifiedly one of our best remedies, and is indicated when there is paresis of *sphincter vesicæ*. It may be necessary to give several drops of mother tincture as a dose for children. In case of failure before resorting to other remedies try its alkaloid, *atropia sulph.* 3x trit., a 1-gram powder at bedtime. It often gives good results.

Causticum.—In paralytic conditions about the bladder *causticum* occupies high rank. It is a great remedy in enuresis with involuntary micturition at night; when coughing, sneezing, or blowing the nose; the whole muscular coat of the bladder is affected. It is to be compared

with *zincum*, *squilla*, and *nat. mur.* for involuntary flow of urine when coughing, or sneezing, and with *ferr. phos.* for enuresis caused from weakened muscular action.

Ferr. phos.—Has involuntary evacuation of the bladder during the *daytime*; the discharge of urine often occurring while the child is playing, but the difficulty does not occur at night.

Benzoic acid.—This remedy is of use when the one prominent feature, *excessively strong odor of the urine, is present.* When the above indication is found, a powder of *benzoic acid* 30, every night for a week or ten days, frequently does good service.

Thuja.—Involuntary urination at night and when coughing, urination frequent and copious, especially in scrofulous children and sycotic persons. I use five to ten drops of tincture to 4 $\frac{3}{4}$ of water—teaspoonful every three hours.

Pulsatilla.—Vesicular catarrh, incontinence of urine, nocturnal enuresis. It is a remedy we have frequently found useful in little girls, given upon its familiar indications.

Cina, *sulphur*, and *kreasote* are at times very useful, and occasionally have each proven to be the remedy of remedies.

While the above list is by no means complete, it comprises a class of remedies of much use in urinary difficulties. With the exception of adjuvants, mentioned hereafter, it gives a pen picture of the medicines used in enuresis during my work of the past ten years.

Many practitioners will look in vain for their familiar remedy, but I have in this paper endeavored to avoid all theorizing, allowing each one to go to the fountain head of *materia medica* for his information, and have confined myself to an individual experience.

There are a number of the newer remedies that come with excellent recommendations, such as *mullein oil*, *vesicaria*, *rhus aromatica*, *saw palmetto*, and others, which I

should not hesitate to use, were I to fail in securing good results with those above mentioned; the latter class being prescribed empirically.

Adjuvants.—The first thing to do, in this as well as other diseases, is to *remove the cause*, so far as possible, whatever it may be. Aside from dietetic errors to be corrected, which are hereafter mentioned, I would urge the careful study of Professor E. H. Pratt's work on orificial surgery. Dr. Pratt tells us *how* to remove sources of irritation occurring at the orifices of the body, and many times a brilliant cure will result, in a short time, that would perhaps have defied all other means of relief.

Electricity.—The galvanic current is of inestimable value in many cases. With sponge electrodes apply one pole over region of the bladder and the other over lumbo-sacral region. Quantity 3 to 5 milliamperes of five to ten minutes' duration, repeated twice a week. In this class of cases electricity is a wonderful remedy, and no one should abandon a case of enuresis without giving it a thorough trial.

Postural treatment.—Dr. Stumpf (*Lancet*, 1895, vol. i. p. 1680) states that incontinence of urine in children may frequently be cured by a very simple mechanical or postural expedient. The child's pelvis is raised in bed so as to be at an angle of from 130° to 150° with the vertebral column, as it rests horizontally, the head being on a thin pillow. By this arrangement the weight of the bladder, as it fills, is prevented from pressing upon the vesical orifice of the urethra, and so does not cause involuntary micturition. After about three weeks of this treatment the child may be allowed to resume the ordinary position, without fear of a return of the incontinence.

Diet.—The following dietetic and hygienic rules are indispensable: not much drink in the evening, no beer or tea; a moderate supper; children should sleep on a mattress, avoiding feather beds. A cold bath every morning is bene-

ficial. The use of cold water will diminish the excessive irritability of the vesicæ, and will enable the patient to retain the urine for the purpose of accustoming the sphincter to more vigorous resistance and the bladder to increased dilatation. The child should be taken up in the evening after a few hours' sleep, and should sleep on the side in preference to the back.

There are other remedies and means employed in the treatment of this annoying difficulty, enuresis; but as this is merely a personal experience in its treatment, and not intended as an exhaustive treatise upon the subject, I will not lengthen the paper. If it will only act as an incentive for others to tell us their treatment and success, this paper will have served one purpose for which it is written.

ON THE TREATMENT OF WOMAN'S DISEASES.*

BY

W. C. LOVEJOY, M. D.

Difficulties.—The difficulties met in the treatment of woman's diseases in the country are more manifold than those the city physician has to contend with. Women in the city consult the gynecologist more freely and thereby are the gainers. The modern social life in the city is very exacting, and if a woman meet the demands of this life, she pays the penalty and her reward may be disease, acute or chronic, of some of her generative organs. Therefore I say that these complaints are more common in the city, and it is a more common habit of such patients to consult a gynecologist. As the country life is more conducive to the physical health of woman, it comes of necessity that there is a smaller class of these diseases to treat, and because of this rarity they hesitate in consulting a physician until the disease is well established. Although our advice may be as good as a specialist's, and the treatment outlined the same, still it is not heeded or carried out as well. Either through the hypnotic influence of their august selves or the larger fee demanded, specialists are able to hold their patient completely under their control, and because of this she sails on to perfect recovery. We physicians in the country have to deal largely with those domestic martyrs, the farmer's wife—a class of patients that daily endure, when suffering from a displaced uterus, dysmenorrhea, menorrhagia, metrorrhagia, or some such disease which requires the rest treatment as much as anything else, a vast amount of misery that a man knows very little of. Still they are

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obliged to be on their feet constantly, from early morn until late at night. Because of this fact the treatment of these patients for these female disorders is very unsatisfactory. Considering that the chances of recovery would be better away from home, I have made it a practice to send a good share of these chronic cases to the hospital. Those of the poorer class, who were not able to pay more than a hospital fee, I have sent to the clinic. The poor woman in the city has the advantage of this gratuitous service. Why not her sister in the country? So then, while I say there are fewer causes operating to produce pelvic disease in woman in the country than in the city, their modes and habits of life, however, are such that they are not able to co-operate with us, in the treatment we may advise.

Medical Treatment.—Adjuvants or aids are called for more frequently and imperatively in gynecology than in any other department of medicine, because many of the symptoms ascribed to drugs for treatment of woman's diseases are not warranted by any proving that they have ever had and are consequently unreliable. Referring to these adjuvants later, I will mention two or three cases in which remedies were verified that are not quite as commonly used as some others.

CASE I. Mrs. M., twenty-eight years of age, married, mother of two children, one abortion, at $2\frac{1}{2}$ months, has been a victim of a profuse leucorrhœal discharge since girlhood. Mother healthy, father of scrofulous diathesis. Patient never of a rugged constitution. From the beginning of the discharge she had been under almost constant treatment. Cal. carb., puls., alumina, and many other remedies had been given without benefit. A careful regulation of habits of life, with a thorough currettement of the uterus after the abortion, failed to help this case. The discharge was very profuse, of a dark brown, smarting, burning character, especially so after her regular monthly period.

She was hardly able to be around on her feet at all. About three months ago I prescribed creasote 3x—the acidity of this drug is very pronounced. Improvement followed immediately after beginning its use, and perfect recovery followed within four weeks.

CASE II. School-teacher, twenty-four years of age. History: Dysmenorrhea, and too profuse and frequent menstruation, bilious temperament. Trouble had continued since the beginning of menstruation; pain was so severe that the patient was often obliged to go to bed for the first day or two at the beginning of the period, which occurred every two weeks, accompanied by severe nausea and vomiting. Ipecac relieved pain, nausea, and lessened the flow—patient going full time; after two months, recovery complete.

CASE III. Mrs. C., married, thirty-two years of age. Mother of four children, had three miscarriages, began flowing profusely about six months ago. Continued for three or four weeks with no improvement, despite the use of what appeared to be the constantly indicated remedy. At this time an examination revealed a uterine polypus, the size of a hen's egg, just within the internal os. I wanted to resort to operative means, but patient not being willing I put her on trillium pend. To my surprise the hemorrhage was gradually checked, and within three weeks she passed the polypus, with relief of all the symptoms. This uterus was also very much enlarged and retroverted. I believe that trillium can be depended upon to control hemorrhage whenever the uterus is enlarged by tumorous growths or pregnancy. It is the remedy I frequently use in *post-partum* hemorrhage; it is of no use in earlier months of pregnancy when hemorrhage occurs. With these slight references to medical treatment, I now pass to the consideration of

Local Treatment.—The tampon may be used to advantage in the treatment of the ulceration of the os uteri, and in displacement and in inflamed and congested conditions of this organ. I have never yet advised a pessary for the

support of the uterus, and have never placed one except in patients who have before worn them and insisted on continuing to do so. For the last three years I have used nothing to keep in place a displaced womb except a tampon of lamb's wool and the use of electricity. This tampon is elastic, and forms an easy, comfortable, and light, non-irritating support, as well as a convenient vehicle with which you may use any local application desired. It should never be inserted or removed except by the physician himself. I have had patients pull the uterus down and out of its place, by removing it themselves. The suction force occasioned thereby was sufficient to produce this result. Therefore, see that you insert and remove the tampon yourself.

General Treatment.—I wish, in conclusion, to refer to cycling as an exercise for women. A physician recently addressed a circular letter to the principal physicians of France, England, and Germany, asking the question, "Is cycling a good exercise for women?" Dr. Dewey says that out of forty-six answers received thirty-four approved of a moderate use of the wheel; nine disapproved absolutely, and three disapproved with reserve. Certain affections are found to be benefited by its use, such as obesity, neurasthenia, hysteria, anæmic conditions, dyspepsia, etc., regulates menstruation, and has proved an excellent adjuvant in the treatment of dysmenorrhea. Of course the usual advice as to the costume being warm and free, and as to the avoidance of the stooping position, by having saddle lower than handle bar, was given. I will also add in this connection, that there is a legitimate and illegitimate use of the bicycle; the temptation is to ride too fast and too long. Nothing but good can come from its temperate use. I would also advise the use of the Christy anatomical saddle, which is so constructed that it supports the body in a natural position. If the above advice is followed its use may be made the ideal exercise for all women affected with the above-mentioned ailments.

THE IDEAL OBSTETRICIAN.*

BY

T. J. MERRYMAN M. D.

AMONG intelligent people the family physician is chosen with great care, but when a lady of refinement chooses an obstetrician, she does so with closer scrutiny, and greater care, than in ordinary cases of sickness.

In the first place, she wishes a physician of gentlemanly appearance, kind and courteous, for, in the trying ordeal of labor, she wants no uncouth actions nor unkind words. Her agonizing sufferings are all that she can patiently endure, without the addition of censure or reproof from her medical attendant and counselor.

Some years ago I attended a Swedish lady in confinement, and my kind treatment and sympathizing words were in such contrast with the rough, scolding manner of the Old-Country physicians in such cases that she remarked about them at different times, and it pleased her so much that she has been a warm friend of mine ever since, and lent me her influence as well as her patronage.

He should also be a man of clean habits and pure breath. How unpleasant for a lady to be compelled to inhale the odors of strong drink or tobacco from the breath of him to whom she looks for aid in the most trying hour of her life! And how much more disgusting and dangerous to find his brain befuddled by alcoholic stimulants!

Recently I treated a lady in confinement who refused to employ another physician simply because she had once seen him smoking a cigar, and she did not propose to tolerate the fumes of tobacco in her sick room.

Some ladies think that none but women should serve as obstetricians, as they seriously object to employing one of

* Written for the Nebraska Homeopathic Medical Association.

the opposite sex to wait upon them in confinement. Now we have no complaint to offer against lady physicians, and are willing to accord to them their due share of obstetrical practice, but we are not ready to surrender to them the entire field along this line; and so long as women are not too modest to marry the opposite sex, we hope that they will not be too modest to employ them as physicians.

Equally important is it that he should be a man of chaste words and pure life. Any one whose lips are defiled by obscene language, or his character marred by licentiousness, is unworthy to serve as obstetrician to a pure-minded woman.

Another requirement is that he should be a close-mouthed man, who will not make public any privacies which he may learn while in performance of his duties.

Of course he should be a skillful man; not only able to treat ordinary cases of labor, but quick to perceive any malformation or abnormal presentation, and know what to do in all such cases, and be able to proceed with calmness and composure; thus alleviating his patient's fears and winning her confidence.

He should also be a man of good judgment, to know when nature, unaided, will do its own work, and when it is best to assist her in the performance thereof. Many women have had life-long sufferings from lacerations produced by unnecessary doses of ergot to hurry up their pains, when nature, unaided, would have performed the work nicely without any laceration whatever; while others have mourned the loss of stillborn children, which might have been saved to cheer and bless their hearts and homes, had the forceps been used at proper time to aid in their delivery, before the life of the child had been crushed out between the bony walls of its mother's pelvis.

He should also be skillful in the use of remedies, for he will thereby be enabled to relieve many of the derangements and sufferings of pregnancy, as well as conduct his patients safely through the dangers of labor and the critical period which follows it.

Some people think that it makes but little difference what system of medicine a physician uses when choosing one for confinement, but if they knew the wonderful efficacy of properly selected homeopathic remedies in the parturient state, it would sweep such thoughts from their minds like frost before the morning sun.

How often a lagging uterus has been stimulated to healthful and efficient contractions, and labor thereby carried successfully on, by the use of a well-chosen homeopathic remedy!

How many a hemorrhage, which otherwise would have proven fatal, has been easily brought under control, by a careful selection of remedies according to the law of "Similars"!

The old idea that nothing can or should be done to prevent a woman's suffering from after-pains, is foolishness to the homeopathic physician, who knows from repeated experiences that well-selected remedies will tone up the relaxed uterus, thereby preventing the exudations from collecting in its cavity, and the consequent painful contractions to expel them therefrom. Then, too, there is that dreaded and dangerous disease, puerperal fever, which can usually be prevented or brought to a speedy termination by proper antiseptic precautions and a careful selection of the indicated remedy. And in this connection allow us to suggest that, in our opinion, there is no remedy in our materia medica equal to *Rhus tox.*, to relieve the fever and quiet the restlessness of a parturient woman.

Brethren in the profession, as we look into the faces of our lady patients, upon whom the curse of the fall and the prediction, "In sorrow shalt thou bring forth," is resting so heavily, and who are reaching out their hands toward us imploringly, and from the depths of their hearts are crying out in anguish, "Doctor, can't you do something for me?" let us ever stand ready to respond with wise heads, cheerful hearts, and willing hands, to alleviate their sufferings to the very best of our ability.

LA GRIPPE IN OBSTETRICAL CASES.

BYS. H. AURAND, M. D.

SINCE 1889 la grippe has been charged with many misdemeanors, and a large army of scientific workers have been on its chase, armed with such weapons of warfare as the microscope, knife, dynamite, and hypodermic shooting instruments. It has been deft and shrewd, and in some measure, at least, baffled the skillful attacks of these fearless and indomitable soldiers. It has won many victories, and its victims in many instances have been selected from the noblest of our noble ranks, thereby seemingly trying to first overcome those who were strong, and best fortified with the fiercest weapons of warfare against its ravages. When we take a retrospective view of the past seven years, we can better know what this pestilential scourge has accomplished in its wake of destruction than we can know what it will accomplish in the future. I am afraid of it and would rather not meet it at all, even upon the terms of peace, for, like the savage Indian, when you have done all you can to comply with the conditions of the peace treaty, it will turn and rend you. I, like the rest of you, have fought it many times both in its simple and complicated forms, and have many times been disgusted with its unprincipled methods and malicious maneuvers. These epidemics have certainly been of great historic note, and have aroused the unabatable interest and research of scientific men in the medical profession everywhere. Great are the numbers of those who have gone to their everlasting sleep on account of its virulence; many others have met with a fate worse than death, because the grave is preferred to the insane asylum;

and there is still another class, whose number is by no means small, who are left physical wrecks, with that agility and brightness which lend enthusiasm and inspire hope in this life, entirely gone. It has been the primary cause of many pains and aches and incurable conditions, but I think as yet it has never been the sole cause of a case of obstetrics. On the other hand, however, it has been a great factor in reducing these cases in number. It is no respecter of persons, but seems to be influenced somewhat by our industrial system, at least holds in common its chief characteristic, viz., that avaricious greed to embrace every opportunity and grasp everything within its reach. It therefore excuses no one but takes advantage of everybody, and especially those who are suffering with other maladies.

Many times the lying-in woman is not excused from experimentally investigating the force of its power long enough to bear her young and recover from the effects. The *Medical Annual* of 1895 says that "R. Pfeiffer of Vienna, who in 1893 found an hitherto unknown, well-characterized, minute bacillus, and succeeded in showing its ætiological significance in influenza, has continued his studies on the same subject." It also states that his attempts at pure cultivation of the bacillus failed except in a few cases in which sputum or pus from the expectoration was fed on agar, when small, perfectly transparent colonies of bacilli were obtained. Attempts to produce further cultivation from these colonies, however, always failed. When the sputum of purulent influenza was spread on blood-agar, it was easy to procure the colonies and to continue the cultivation through successive generations, while inoculations on any other nutrient soil remained sterile. Further investigation showed that the constituent of the blood, required by the bacillus, is the hemoglobin of the red blood corpuscle. This author has never found the bacilli in the blood, but has frequently found them in

the kidneys and spleen. Arlong was among the first to find in the blood of influenza patients, at the time of febrile invasion, an element cultivable and inoculable in animals. In looking up the subject I find that it is the almost universal verdict of those who are engaged in the cultivation of the la grippe germ, that blood cultures of the microbe gave better results. The supposition therefore is that these micro-organisms find more favorable vital condition in the blood than any artificial medium. I make and quote these statements to show what the condition of the blood of the woman who is nearing term might be, if she is unfortunate enough to have contracted la grippe several weeks or months before this important time.

Whatever significance the bacteriological factor may bear to la grippe, I like very much the opinions of Dr. Julius Althaus of London, and Dr. E. M. Hale, in whose work it is given. They refer all the symptoms to irritant poisoning by a grippal toxine on different centers of nervous force in the medulla oblongata, and the peculiar fever is attributed to congestion of the thermolytic center in the bulb, by the irritant effect upon it of this grippal toxine. Hale says "the infection is supposed by some to arise from the secretions of the nasal passages, but this can hardly be, for many cases have no discharge whatever." "The grippal bacillus must enter the blood as does the bacillus of malaria. In fact these two bacilli have many effects in common. Both are protean in their manifestations; hardly an organ or tissue escapes their ravages; they poison the brain, spinal cord, and the whole nervous system; the whole extent of the mucous surfaces; the lungs, liver, heart, uterus, ovaries, muscles, and glands." If we grant all this, must we not consider that the woman who is approaching the lying-in term, with la grippe in its true form, is in a very precarious condition, and should necessarily receive all the benefit of reasonable, modern antiseptic treatment, whether the immediate symptoms

call for it or not ; because of the already existing poison in her system ? Here we can easily understand how the most violent form of septicæmia may obtain from the slightest absorption of lochia clot or membrane. I have always believed that, in the healthy woman and normal case of obstetrics, the interuterine douche is not only unnecessary but in many instances, where the patient is susceptible to the solution used, absolutely harmful. I remember, while in college, hearing Dr. Foster relate some of his experience on this line. He was called in consultation with a physician who was using injections of a bichloride solution.

The attending physician was continuing this method of cleansing on account of the persistent high temperature with which his patient was suffering. Dr. Foster could detect no symptoms which called for this treatment, and, upon questioning, found that the temperature always reached its highest point shortly after the use of the injection. He suggested that the douche be discontinued, which suggestion was followed, with the happy result of quickly reducing the temperature, and the patient made a hasty and perfect recovery.

We as physicians cannot improve upon the healthy physiological action of the organs of the human body. We acknowledge this when we study their histology and action, and try to imitate their practice ; and yet how many times do we meddlesomely interfere when all is going well. Apropos of this question of meddlesome interference or harmful medication, I wish to ask, Do we need to wonder that so many cases of la grippe, whether complicated with obstetrics or not, result fatally, when we stop to consider the symptoms and nature of the disease, and the treatment that is so many times used ?

The one symptom which I believe determines more than any other whether you have a case of la grippe or not is that "tired feeling." Every organ of the body seems to be worn and weary ; so much so that they lag in the perform-

ance of their functions. The entire organism seems at times to be completely exhausted in its arduous task to eliminate from the blood the grippal toxins. In its extreme efforts to rid the system of this foreign material we find the body frequently bathed in a copious perspiration. A great effort is required on the part of the patient to move a hand or foot or even a muscle. This being the condition of a simple uncomplicated case of la grippe, what might we expect when it is complicated with a case of obstetrics, when the patient is called upon for an extra amount of strength and vitality. I believe that it is absolutely dangerous in this disease, whose chief characteristics are shown by profound and marked depression on the body and mind, to administer such drugs as antikamnia, phenacetin, morphine, etc., in large enough doses to get the depressing after effects. In speaking of la grippe Dr. Dinsmore of the old school says he thinks that some of these cases of weak heart may be due to too much medication, too large doses of phenacetin, acetanilid, and antipyrin.

Drs. Conn and Russell, also of the old school, each saw one case of delirium lasting for months. In Conn's case the delirium recurred the following year. Dr. Palmer says that he regrets having ever given acetanilid, antipyrin, etc., in these cases. When our old-school brethren begin to condemn such medication as this, the homeopaths certainly ought to take warning. If the supreme weakening effects of the disease and the medication should appear at one and the same time, how could we expect our patient to survive? My opinion is based upon my own experience of course, that the closer we adhere to the homeopathic medication in these cases, the better will be our results.

Notwithstanding this, I think that I can heartily recommend, in some cases, the use of sulphur and iodo-phenique, and also quinine.

As a douche I use, and like very much, a solution of

creolin; about 3 drams to a quart of sterilized water. As a means of application I like the fountain syringe, with Jennison's uterine douche. The *Medical Annual* says that Dr. Preoleau is of the opinion that certain rare cases of inevitable puerperal infection occur in spite of vigorous antisepsis; being met with when delivery takes place in an infected or mephitic atmosphere, or coincident with the evolution of an infectious disease, in a patient with previous genital or para-genital disease. However, these conditions do not necessarily imply a fatal puerperal infection. The mechanism of such infection appears to be the entrance of air charged with noxious principle into the genital area, or deposition at the site of the placenta wound of germs brought through the blood of the parturient; these germs increasing under favorable conditions, such as a constant temperature, appropriate medium, and diminished phagocytosis from the infection already existing. The new puerperal infection, in turn, penetrates into the blood and aggravates the former disease. This seems very reasonable; and, if true, the interuterine douche is an absolute necessity, from the very beginning, in these cases. Dr. Boners cites a case of septicæmia of malarial origin in which quinine produced good effect. Dumont relates a case of puerperal pseudo-infection of intestinal origin due to the coli-bacillus, and J. Hayens a case of a similar nature. "Chamberlent of Paris was called to see a lady, in the eighth month of pregnancy, who had suffered for a few days from fever, headache, colicky pain, and violent diarrhea; evidently an attack of influenza then present. Labor occurred one week later. No movement of the child had been felt from the day that the colic set in. A dead macerated child was delivered. There were no hemorrhages in the placenta. The patient made a speedy recovery." "Dr. Omer of Constantinople says that miscarriage and premature labor were frequent complications of influenza. In a Turkish primipara the fetus, which died during an attack of la grippe,

was putrefied, the presenting abdomen allowing the intestines to prolapse. Version and extraction were performed, and the woman recovered."

I wish now to report a case from my own practice. On the 16th day of last February I was called to see a plump, hearty-looking American lady, whose age was twenty-one years, and who was pregnant for the first time and within a few weeks of term. She was suffering with neuralgic pains through the back, hips, abdomen, and down the thighs. The mother and husband supposed that these pains were indicative of coming labor, and that the child would soon be born. I made a digital examination, which revealed a very soft and flabby condition of the organs and the os dilated to about the size of a silver half dollar, and the head of the child crowding well down into the pelvic cavity. I made the patient as comfortable as I could, by putting her to bed and applying, externally, dry heat. This was very agreeable, as she complained of being somewhat cold. I too supposed that labor was coming on, and told them to call me at any time when the pains became frequent and expulsive. I was not called, but on my return the next day I found her somewhat better. She had no fever, pains less severe and less frequent. Under the influence of colocynth the pains gradually subsided, but were followed by spells of heated, flushed, and nervous feeling, which were irregularly alternated with cold in spots.

The appetite remained good, the bowels were loose and somewhat bloated, with much rumbling and belching of gas. About the 22d of February, or six days after I first saw her, she had every indication of having taken a severe cold. The eyes were congested, weak, and watery; heated discharge from the nose which was profuse and watery, and a general stuffed-up feeling as with acute catarrh. There had been no exposure, and we could not see how she could have taken cold. *Allium cepa* and *gelsemium* were given, with marked relief in a short time. The bowels

had become natural, but only to be followed with a loose catarrhal discharge, which continued more or less throughout the entire sickness. On account of her extreme weak and exhausted condition, she now preferred to remain in bed all the time. These symptoms continued with but little variation until the early morning of February 29 (that very unfortunate birthday), when I was summoned to appear at the bedside of my patient as soon as possible. After my arrival and examination I felt fully satisfied that labor was now coming in earnest. The severity and frequency of the pains increased rapidly, but muscular weakness seemed to prevent the patient from making the most of them. After several hours' labor, the result of which gave us a fully dilated os and placed the child's head well down to the inferior strait, her strength began to fail. After a few ineffectual efforts I decided to apply the forceps, which I did and soon brought into the world a ten-pound boy. No harm done that I could discover except to slightly bruise the parts and rupture the perineum. With slight traction on the cord and pressure on the fundus of the uterus the placenta came away freely and fully. I did not stitch the perineum, and here you may charge me with neglect of duty, but the condition of my patient taken into consideration, my judgment said no.

For two days she did nicely, no unlooked for symptoms, except extreme soreness of all the muscles. On the third day without a chill, but with slight rigors and severe aching, the temperature rose to 103° ; this I thought might be due to the natural function of the breast. This temperature not only continued, but on the following morning registered 104° . I then lightly curetted and washed out the uterine cavity. Arsenicum 3d, and baptisia 3d, were given every half hour in alternation. The severe symptoms did not abate, but in the evening the thermometer under the tongue registered 105° . I then called Dr. Burbank in consultation. We explored the uterine cavity with a pair

of placental forceps, and obtained a small amount of thick bloody-looking mucus. We used as an interuterine douche a solution of creolin, and added to the internal remedies sulpho-phenique, a tablespoonful every three hours.

On the following day I found the temperature $103\frac{1}{2}^{\circ}$, under the same treatment it remained so for twenty-four hours, when it again rose to 105° . I persistently continued the daily use of the interuterine douche, and occasionally used the dull curette very lightly. I sometimes obtained small traces of shreddy mucus. The temperature began to come down, and with the letting up of all the other urgent symptoms gradually reached 101° . Our baby was now two weeks old and everything apparently doing well, but not to continue, for on my next visit I learned that my patient had suffered a slight chill and the thermometer again registered 103° . I began to search for the cause and found it in the left breast. Marked symptoms of caking were present, and the mother, evidently believing in the law of similia, had already begun her process of caking externally. I now gave bell. and phytolacca internally, and applied warm phytolacca compresses externally. With this treatment she grew slightly better, but on the third day (after the breast complication) she had a most violent chill, after which the thermometer under the tongue registered 107° . This, to me, was somewhat alarming. I prescribed quinine in 4-grain doses every three hours, and, each hour between, 1 drop of the tincture of veratrum viride (used Wyeth's tablets of Norwood's tincture). The temperature came down rapidly; in twelve hours it dropped to 101° . The family were somewhat nervous over this last experience and wanted old-school counsel; according to their request the oldest allopath in the city was called. He felt the breast, abdomen, and pulse of my patient and looked at her tongue, asked no questions, but importantly remarked that there was nothing alarming,

that the patient was all right, except the little trouble with her breast.

It was evident now that we were to have a gathered breast, so we applied a linseed poultice and gave hepar sul. and bapt. internally. I could see no apparent change for one week; the breast seemed to get neither better nor worse, and the temperature remained at 101° . As I remarked before, the bowels had been moving rather freely throughout most of the sickness, until now they were somewhat constipated. In trying to evacuate the bowels the patient strained pretty hard, shortly after which she experienced an uncomfortable feeling in the lower part of the abdomen; this continued to grow worse until it resulted in real uterine contractions, which were the cause of severe pain. I was sent for, and upon examination found the uterine cavity filled with clotted blood. This was more than three weeks after the birth of the child, and the flow had entirely ceased. I dilated the womb, and with the placental forceps and curette removed the clotted blood. In twenty-four hours the womb was again filled and the same kind of pains experienced, when I resorted to the same treatment, but in addition, after washing out well, I injected a weak solution of Pond's Extract of Hamamelis. Internally I gave cimicifuga and sabina. To my consternation on the following day I found the lady suffering with the same character of pains. I very thoroughly followed out the same line of treatment as before, which proved to be effectual and ended this part of the difficulty. But another complication was on deck, and now for the first time she was unable to voluntarily pass her urine. I drew the urine and left a soft rubber catheter, with instructions to use it when necessary. Several days later, when attempting to empty the bladder, the nurse was unable to pass the catheter, after which the patient suffered with violent tenesmus. I was immediately called, and found her in agony with spasmodic stricture of the urethra. This

I relieved with the sounds and gave cantharis and apis mel. internally, and directed the nurse to keep cloths wrung out of hot water applied externally. The two complications last mentioned lasted for about one week; during this time the breast was constantly poulticed. Three-fourths of the gland, with some of the adjacent tissue, seemed to be a solid mass. As soon as a spot softened up I used the lance, and continued this until I had lanced in five different places. It now presented a hard, nodular, angry appearance; the several openings discharging an acrid, watery fluid, and the patient complained of considerable burning pain. For this condition we used externally a compress of camphorated olive oil, to be kept warm with the hot-water bottle, and gave arum triphyllum internally. It is indeed surprising how much the homeopathic remedy will do, when given according to its indications. Here arum triphyllum was undoubtedly the simillimum, for it conclusively proved itself by rapidly clearing up every vestige of the trouble of the breast. This was on the 5th day of April, and on the 9th I made my last visit; the patient being in a fair way to an uninterrupted recovery. In conclusion, I wish to call attention to the following interesting points:

First. The great tendency to puerperal septicæmia.

Second. The necessity for the most thorough antisepsis, whether the immediate or local symptoms called for it or not.

Third. The peculiar exhaustion and lack of muscular power, and also the demands for manual or surgical interference.

Fourth. The dangers which are peculiar to this disease, following the use of the coal-tar derivatives or any depressing medication.

Fifth. The peculiar hemorrhage and retention of blood in the womb.

UTERINE ATROPHY.

BY

EUGENE HUBBELL, M. D.

UNTIL recent years comparatively little has been written or even known of uterine atrophy. Probably official philosophy has done more to throw light on this subject than any other means. The causes are but little understood as yet. The symptoms are not yet well outlined. Authorities generally agree on two forms, viz., congenital and senile, or acquired atrophy. The former is a general retardation of development of the uterus and often accompanied by the same condition of its appendages. In this form of atrophy the uterus is normal in its formation, but small in size, possessing thin walls and a pale, anæmic condition. According to Peuch, the atrophied uterus weighs about 400 grains, instead of 675 to 700 grains as in the normal. The patient usually manifests a general lack of development. Pozzi says, in his work on "Medical and Surgical Gynecology":

"Uterine atrophy is to be attributed to a congenital predisposition of unknown origin. It has been supposed to be due to chlorosis or tuberculosis, but it seems to me that cause and effect have been reversed; the woman with this malformation possessing a defective nervous system and general innutrition because of the genital lesion."

Complete or partial amenorrhœa, dysmenorrhea, displacements, many mental and nervous symptoms, hysterical and epileptic attacks accompany the condition in many women, while others are strong and of a masculine build.

In senile atrophy the uterus gradually decreases in size after the climacteric until at old age it is very small, and the vaginal cervix has, in some cases, wholly disappeared.

When no resulting symptoms occur this is a normal condition; but if there have been rapid child-bearing, exhausting diseases, laceration of cervix, endometrium, or perineum; ovariectomy, cervical amputation, etc., there will frequently follow superinvolution, accompanied by more or less reflex symptoms, many of which we do not yet well understand. After operations on the female generative organs occasional dilatation of the uterine canal, to prevent too rapid superinvolution, is advisable and often necessary. Rapid atrophy after exhausting labors occurs, it is estimated, in about one per cent. of cases, but this form is sometimes self-limited, and the uterus again assumes its normal size and function. Ovarian irritation, neuralgia, chronic rheumatism, dementia, insanity, many heart symptoms, defective digestion and nutrition, anæmia and chlorosis are often referable to uterine atrophy.

As the treatment of congenital and acquired atrophy varies but little in a general way, I shall include both under the same heading. Exercise in open air, sea-bathing, general tonics is about the general run of medical advice for this malady. Some have recommended electric uterine stems. Others have employed galvanism and faradism, with the general opinion that but little can be done for this trouble.

I have had the most satisfactory results from so-called "official methods." The patient is prepared as for any intra-uterine treatment (*i. e.*, thoroughly aseptic), and graded uterine sounds are passed carefully into the uterine canal (under local anæsthesia if thought preferable), to No. 14 or 20 or more. The canal is then wiped clean and packed with gauze or candle-wicking for six to twenty-four hours, according to condition and age, in the first treatment; and patient confined to bed, usually for a few days. All-round official work should be done, when necessary. After-treatment consists in passing the sounds and conducting the galvanic or faradic current through the sound, the negative pole attached to the sound, the positive over spine or abdo-

men for five to ten minutes at each séance, repeating them every two to ten or even thirty days, until there is a healthy reaction in the uterus and it assumes its normal size and function.

In some cases the use of the sounds and electricity will be all that is needed. Uterine stems will give some benefit in a few cases, but should be worn only a few days at a time, then removed. Great care must be used when employing full dilatation the first time, especially if the patient is under general anæsthesia, as the uterine walls are thin and may be perforated or injured if too great force be used. The proper tact and skill come only by experience. A few weeks of above treatment will bring the desired result in most cases.

Before closing this paper, I wish to cite a few cases to better illustrate the subject.

CASE I. *Æt.* eighteen. Menses suppressed two years; very emaciated; has severe night sweats, hectic, diarrhea, etc. Uterus atrophied, measures $1\frac{1}{4}$ inches; very pale and inactive. First treatment; dilatation by sounds, packed uterus with antiseptic candle-wicking; renewed same in twelve hours; then gave intra-uterine galvanic treatments every three days for two weeks; positive pole to the uterine electrode, negative to abdominal electrode. I then reversed the current for two treatments, when a very slight flow appeared; then gave as before every week till time for next period, when the poles were again reversed, which caused quite a natural menstrual flow, which has since continued regularly. She has regained her usual strength and vigor a year ago, and now enjoys good health.

CASE II. *Æt.* thirty-three. Unmarried; daughter of old-school physician; has been very irregular in her menstruations all her life. Has taken large amounts of iron to bring on the menses; would go two or three months without menstruating. Uterus $\frac{3}{4}$ inch deep, very small, retroflexed. Has a great deal of dysmenorrhea, neuralgia,

headaches, gastric disorders, melancholia, and troublesome cough, etc. Treatment with sounds and galvanic current as before, and ending each treatment with faradic current. Menses soon became normal in quantity, and appeared regularly. General health much improved.

CASE III. *Æt.* twenty-four. School-teacher. Quite well until three years ago, though has never menstruated freely or regularly. Two years ago she was taken with the fever, then epidemic at Grand Forks, N. D. After a very serious sickness she recovered sufficiently to go to her home in Ohio. She began to fail; finally took treatment of different physicians, but gradually declined in spite of their treatment. When I first saw her she was hypochondriacal nearly to the point of insanity; suffered constantly with an occipital headache, and almost complete loss of memory; menstruated quite irregularly, without pain, but flow very pale and scanty; no leucorrhœa; bowels constipated; uterus measured $1\frac{1}{2}$ inches, and was strongly retroflexed, and quite sensitive to touch. All-round orificial work was done, and the uterine canal thoroughly dilated and packed while under anæsthesia. Slight adhesions were broken up and uterus placed in natural position; packing removed in six hours. Made good recovery. After three weeks sounds and galvanism were used as before. Four weeks of treatment completed a cure. It is now nearly a year since the last treatment, and she has been at her chosen vocation during the past school year, and is well, happy, and full of hope and cheer.

In all these cases the uterus soon attained the normal size, color, position, and function.

CASE IV. Mrs. C., *æt.* forty-eight. Passed climacteric four years ago, since which time she has been feeling ill, saying she was going to die, or that she was dying; weak heart action, palpitation, dyspepsia, pain in the back and left side under shoulder; constipated, bowels move only after cathartics or injections; very despondent; frequent

deep sighing respirations. Uterus atrophied, retroverted, pale, non-sensitive. Treatment: passed sounds once in two weeks (four times in all) up to Nos. 12 and 14, English scale. Applied clycid; also had her use rectal dilator twice a week. Improvement from the first, till in a few weeks all symptoms had disappeared, except pain or ache in left side and shoulder, which was finally removed by self-suggestion (or Christian Science?). She formerly had no appetite, and was very pale and anæmic, but now all is changed. She is bright and cheerful, attends to her own household duties, and says nothing about dying.

Most of these cases received the homeopathic remedy before, and during the local treatment some had none. Remedies seem to play but a very small part in the cure of uterine atrophy. Conium, iodine, pulsatilla, and ferrum are the most useful remedies, but others may be required in some cases.

THE ALEXANDER OPERATION.*

BY

MYRON H. PARMELEE, M. D.

DURING the last two years a marked change has taken place in the views of many operators as to the value of this procedure. Five years ago Dr. Howard Kelly's ventrofixation operation was absorbing all gynecological attention for the cure of retro displacements; but better methods of reducing the size and weight of a displaced uterus have led to a revival of interest in Alexander's operation, which had been all but abandoned in this country.

Still many able men declare against its performance on grounds as follows, viz.:

First. That the operation is a dangerous one.

Second. That there is too great difficulty in finding the ligaments.

Third. This operation causes abortions.

Fourth. Hernia and invalidism are likely to follow it.

Fifth. It is too limited in its application.

Sixth. There are other and better methods of obtaining like results.

First. That the operation is dangerous. Such an objection can only come from one who has not learned how to prevent septic danger by proper methods of surgical cleanliness. The Alexander is not more to be feared than any of the cervical operations, with proper attention to maintain an aseptic field.

Second. That there is too great difficulty in finding the round ligaments, or that they are so small and fragile that

* Read at meeting of Ohio Homeopathic Medical Society, Piqua, O., May 12, 1896.

they will break when tension is put upon them. If there is a uterus and appendages—there must be *two* round ligaments, and with care and a due attention to the anatomical guides, they may be found—certainly in by far the greater proportion of cases attempted.

To be sure they are sometimes small and sometimes soft from prolonged stretching; but the fingers that have been educated to handle tissues carefully will rarely rupture them.

Dr. Edebohls may have demonstrated four cases where, at the external ring, the ligaments, instead of descending to attach themselves upon the pubic fascia, turned upward and outward to find a landing place; but the majority follow the definite anatomical arrangement. Suppose that after an hour's search you "give it up"—what then? You have only a minute skin wound to close, and your patient is no worse off than before.

Third. The Alexander operation causes abortions. And as an additional argument that then the ligaments stretch and the uterus becomes retroposed as before.

Dr. Clement Cleveland has investigated this point. He says, "among my own cases are a number of patients who have gone to full term, and have been examined repeatedly afterward. In *no one* instance has the uterus been found out of place."

What more can be said? I regard Dr. Cleveland's statement as perfectly true.

Fourth. Hernia and invalidism are likely to follow. In my own series of six cases (too small a number to base any deductions from, however) the reverse has been in each one the rule. Immediate improvement has been most marked. One operator in eighty-seven cases had but two hernias. Those who slit up the inguinal canal in their search for the ligaments (and this modification of the original operation ought therefore never to be followed) have a much larger percentage of hernias.

Fifth. It is too limited in its field of application. This is a valid objection to the extent of the field of the operation; but not to the operation when its indications may be clearly defined.

Sixth. There are other and better methods of obtaining the same results. By this is meant "ventrofixation," Wylie's or Palmer Dudley's intraperitoneal shortening of the ligaments, and Mann's operation of sewing to the internal ring. In all of these the abdomen *must* be opened, making them much more dangerous; therefore, in my judgment, comparisons are all in favor of the Alexander. Vaginal fixations—whether Schücking's, Mackenrodt's, or Pratt's—from the enforced flexions which they produce, with the increase of symptomatic misery flowing from those flexions—are not to be thought of.

The Indications.—Alexander's operation may be done in any case of uterine retroposition—with or without ovarian prolapse—where the organs can be readily replaced. Or, if there are adhesions—that can be broken up by posterior-vaginal incision, and the fundus can be liberated.

The Operation and its Technique.—The preparation of the patient should be as carefully done as if a cœliotomy was to be made. The vagina should also be rendered thoroughly aseptic, for the first step in the operation should always be to *curette* the uterus. Lack of curettage has been the point of departure for some of the failures in this operation in the past. Should there be a cervical laceration, repair it, and then carefully replace, even to anteverting the uterus, and make the Alexander operation.

Carefully locating the pubic spine, make an incision from one to two inches in length, carrying it through the integument and subcutaneous fat straight toward the antero-superior spine of the ilium. This exposes the external ring. By separating the incision with the left thumb and forefinger, and pressing on either side of the ring, on

the pillars, the intercolumnar membrane generally puckers, and, being cut through, a bunch of fat protrudes. This bunch of fat is the guide. On picking it up, the ligaments can be drawn upon and isolated from the nerve which runs along it, and can be freed from peritoneum. It should be drawn out about four inches. Two silkworm gut sutures are introduced, including all the tissues and the ligament, and the free and exposed portion of ligament is cut off. The other side is treated in the same manner. The modifications of the original operation are not to be depended upon. Dr. Cleveland's procedure of piercing the fascia and anchoring the end of the ligament under the mons, he admits gives no better results than the simpler procedure. Dr. Franklin Martin's plan, of tying the ends into a reef-knot under the skin and suturing, is objectionable from the fact that it creates and leaves an ugly bunch in a prominent bit of their anatomy, for women to complain of.

A dry boric-acid dressing completes the operation. Now, if there has been a ruptured perineum, that should, last of all, be attended to. These different operations can all be completed at the one sitting. The after-treatment is conducted on very simple lines. Rest, in any position, should be enforced for at least three weeks, and the silkworm gut sutures should be left in place and undisturbed for at least that period, and longer, if possible. If it can be done, allow the patient to urinate naturally, from the first; in other words, dispense with the catheter, if you can. Silkworm gut, with a through-and-through stitch, is preferable to any buried suture in these cases, as it allows of a slight drainage, which is of advantage. In retroflexions be sure that the fundus is lifted up and is well forward, else, when you draw upon the ligaments, you may flex it upon itself only more and more.

A pessary is *not* needed after these operations.

THE CONTAGIOUSNESS OF SCARLET FEVER.

BY

DR. OSCAR MARTINY.

(TRANSLATED BY B. F. UNDERWOOD, M. D.)

AS is well known, it is the general opinion that the contagiousness of scarlet fever is most active during the period of desquamation. We find in *l'Art Medical* the following notice of a paper read before the Société Médicale des Hopitaux, of Paris, upon this subject.

M. Lemoine read a long paper upon the contagiousness of scarlet fever, apropos to the epidemic which he had observed during the past year in the army at Paris. He recalled the fact that for a long time the opinion prevailed in the medical corps, that scarlet fever was particularly contagious during the desquamative period, and that the scales were the means of contagion; and that for some years a number of physicians, however, believed that contagion existed from the outset of the disease before the eruption appeared—from the onset of the scarlatina angina. He cited the opinions of a number of writers in support of both views.

It has been easy to control in the regimental infirmaries those affected with the disease at the onset, as the patients recognized as having the disease were immediately removed from the general hospitals, but as the scarlet fever continued in the dormitories of the barracks, it is evident that it is at the onset of the disease that the contagion is active. Dr. Lemoine cited many instances of contagion in favor of this theory. *Per contra*, he cited many cases which appeared to demonstrate the fact that contagion did not take place during the process of desquamation.

A man entered the Val de Grace the 27th of March for a

sore throat ; he was discharged the 6th of April to join his regiment, where he slept in a dormitory with twenty-five men who had never had the disease ; he was employed every day at the *cantine*, where he came in contact with the family of the sulter and all of the regiment. The 24th of April he began to desquamate, and in a short time the desquamation became so abundant that, according to his expression, he could gather the epidermic scales by the handfuls. Desiring to retain his place, the man did not present himself to the surgeon until the end of the month of May, when he was taken with severe pains in the lumbar region. At this time he still showed traces of desquamation upon the hands and feet. The regiment to which this man was attached sent to the hospital only four cases of scarlatina (the 10th, 11th, 19th, and 20th of April), all before desquamation had commenced with him.

M. Le Gendre is of the same opinion, and believes that all physicians in infants' hospitals are in accord upon this subject. For him, scarlet fever is above all contagious at the outset.

He cited many instances, and related among others the history of a woman who had been sent to the Hospital Broca as being attacked with syphilitic angina, but which proved to be the onset of scarlatina ; she remained in the hospital only twenty-four hours, but in that time communicated the disease to three syphilitics.

M. Sevestre believes contagion possible at the beginning and during the period of desquamation.

The facts cited by M. Lemoine are interesting, and confirm the opinions previously expressed by MM. Sevestre, Girard, Cadet de Gassicourts, and others who believe in the contagiousness of scarlet fever during the eruptive period, and also the cases reported by Randsonne indicating the possibility of danger during the period of invasion. These facts should arouse our attention to the dangers of contagion in all cases of scarlatina.

ALBUMINURIA OF PREGNANCY.

BY

FLORENCE N. S. WARD, M. D.

(Concluded from p. 384, July, 1896.)

AUTHORITIES who believe that the nerve centers are at fault cannot bring forward any evidence to show that certain centers have been involved. *Post-mortem* examinations show them intact.

Before drawing our conclusions, let us turn, for a moment, to the physiological processes that are taking place in the maternal organism in a normal pregnancy. There is first a noticeable increase in activity of all the organs, followed by hypertrophies, notably in the heart, that it may send larger quantities of blood to meet the increased nutritive demands, and also to pump it to larger areas. The liver, spleen, kidneys, and thyroid gland likewise become hypertrophied. Think of the great nervous vitality necessary to carry on these processes besides developing the fetus.

Should the nerve force be sufficient for all demands, the physiological process proceeds harmoniously and it is normal. If by reason of lack of vital power to carry on these vegetative functions, by reason of exhaustion or of some dyscrasia within the system, we have primarily an impairment of function, first observed in the liver, as proven by Massin in the Imperial Institute for experimental medicine in St. Petersburg. The liver being the oxidizing agent for animal products, with its impairment there is the accumulation of the products of defective oxidation, which circulating through the blood, act deleteriously upon the parenchyma of different organs, particularly the kidneys, liver, and spleen, and induce pathological changes in these

organs. These result in a further impairment of their function ; the ptomaines or leucomaines increase in the system until the auto-intoxication is so great that the dreaded seizures of eclampsia result. The whole picture is that of a system overwhelmed with a poison ; the closest clinical analogy being found in the picture of acute poisoning by corrosive sublimate. Professor Olshausen relates two instances of women dying in the hospital from corrosive sublimate poisoning, and so identical were the spasms and accompanying symptoms with eclampsia seizures, that they could not be diagnosed clinically from eclampsia.

Thus certain definite deductions can be drawn.

I. Albuminuria of pregnancy or eclampsia is a disease peculiar to itself, and characterized by a very definite array of clinical symptoms, and by certain pathological changes of the organs as shown in the dead body.

II. It is never manifest except as an accompaniment, or following the development, of the fetus within the maternal organism.

III. Clinical observation can furnish no evidence of external conditions sufficient in themselves to produce albuminuria of pregnancy.

IV. Physiological research and observation show that the disease is the result of impaired action of certain organs within the body, principally the liver, spleen, and kidney, resulting in the production of leucomaines and an auto-intoxication.

The principal deductions for us, as homeopathic physicians, is that the disease is a morbidly vital force, amenable to our remedies. Its best treatment consists in watching our pregnant patients, in sustaining their vital forces, and in controlling slight deviations from normal, as soon as they appear.

To this end the examination of the urine is of prime importance, as it is the only fluid that bears evidence of the activity of the eliminative processes within the body.

In suspicious cases, not only should there be daily examinations for albumin, but also for the amount of urea excreted, the quantity of urine passed in twenty-four hours, and also microscopical examinations. Each point is necessary for making a decision as to what course to pursue.

Besides these points, we must bear in mind the peculiarities of each patient, particularly the quality of the nervous system.

Some patients with but slight leucomain poisoning, but having marked neuropathic tendencies, will develop eclampsia, while others, with the system almost overwhelmed with leucomaines, will show no nervous manifestations.

Should the evidence point to increasing inability of the organs to perform their work, then the indication is to end the pregnancy and save the mother, and if the gestation be far enough advanced, possibly the child.

I shall not enter into details of the hygienic care, nor of the remedies indicated in this disease. Both have been so admirably presented at previous meetings, particularly by L. L. Danforth, M. D., of New York, that nothing is left to be said on the subject.

LITERATURE.

Lésions Anatomiques que l'on trouve dans l'éclampsie puerpérale, par Bouffe de St. Blaise.

Traité de l'albuminurie, par le Dr. Senator.

Beitrag zur Eklampsie auf grund von 81 Fallen, Dr. Oscar Goldberg.

On the Treatment of Eclampsia, Professor Zweifel. *Centralblatt für Gynäkologie*, 1895, Nos. 46 and 48.

Intermediate Product of Metabolism as the Cause of Eclampsia, Dr. W. N. Massin.

Centralblatt für Gynäkologie, No. 42, 1895.

Contribution to the Etiology of Eclampsia, Dr. E. Gerdes. *Centralblatt für Gynäkologie*, No. 20, 1892.

Puerperal Eclampsia, S. Seabury Jones, M. A. *Medical Record*, April 25, 1896.

On Eclampsia, by Robert Olshausen (Sammlung Klinischer Vorträge, von R. von Volkmann. Neue Folge, No. 39, Leipzig, 1892).

Ueber Eklampsia Puerperalis, Ludwig Heinrich.

Ein Beitrag zum Theorie der Eklampsie, Dr. Otto V. Herff.

Ueber Eklampsie, Angel Konst Rombi.

Beitrag zur Kenntniss der puerperalen Eklampsie, Rudolph Gettkunst.

Book Reviews.

All manuscripts for publication, and all books for review, in this journal should be sent to the Publication Office, 133 William Street, New York.

A TREATISE ON SPERMATORRHEA, IMPOTENCE, AND STERILITY.
By WILLIAM HARVEY KING, M. D., Professor of Electro-therapeutics in the New York Homeopathic Medical College, editor of the *Journal of Electro-therapeutics*, etc., etc. Cloth, \$1.50. New York : A. L. Chatterton & Co., 1897.

The author of this work, having had an extended experience in the treatment of these diseases, speaks, therefore, upon the subject as one having authority. There is probably no other class of diseases so capable of perplexing and annoying the general practitioner as these, and anything that will throw light upon the subject will be gladly welcomed, not only by physicians, but by those affected ; for, as it stands to-day, so little success is had by the majority of physicians in the treatment of these diseases, that nearly all of those affected fall into the net of the irregular. The treatment given by Professor King includes the homeopathic remedy, a comprehensive résumé of the electrical treatment, and hygienic mechanical adjuvants. The accepted treatment in many of these cases is largely surgical, but the author holds the diseases are essentially of a neurological type, and, therefore, should come more under the physician's than the surgeon's care.

Messrs. Lea Bros. & Co. announce a new "Treatise on Obstetrics. For Students and Practitioners. By Edward P. Davis, A. M., M. D., Professor of Obstetrics and Diseases of Infancy in the Philadelphia Polyclinic, Clinical Professor of Obstetrics in the Jefferson Medical College of Philadelphia." In one very handsome octavo volume of about 700 pages, with about 200 engravings and many full-page plates in colors and monochrome.

It will be found more comprehensive than ordinary treatises, as it deals with those cognate subjects best handled in close connection with their obstetrical precedents, such as the repair of lacerations and injuries, the care of the mother, of the infant, jurisprudence of midwifery, etc.

Materia Medica.

Calcarea Fluorica is said to be specific for flatulency during pregnancy.

***Berberis Vulgaris* in Enuresis.**—Dr. D. A. Waldron.—Sticking, cutting pain from kidney to bladder and ureter, a sensation as if not emptied.

***Lilium Tigrum* in Uterine Disease.**—Dr. A. C. Cowperthwaite.—The provings of lilium are rich in uterine symptoms, and its curative virtues in various disorders of this organ have been repeatedly verified. It causes pressure, heaviness, and other symptoms of uterine congestion, and this has led to its remarkably successful use in chronic metritis, and consequent uterine displacements. It is more especially useful in version with great pressure against the rectum, causing constipation, and to a less extent against the bladder, causing vesical irritation.

***Anacardium* in Pertussis.**—Dr. Conzelman.—The mental condition characteristic of this remedy is always present. The child is cross and ill-tempered; paroxysms of cough are brought on by vexation, the child coughs whenever it gets angry; paroxysms every three or four hours. After the paroxysm the child is almost suffocated, loses its breath; cough excited from tickling in throat. Cough at night without expectoration, during day cough *with* expectoration. Sweetish tasting mucous or yellow purulent acrid expectoration. Coughs every time child eats or speaks; vomit of food without relief, much sneezing; after cough yawning and sleepiness.

***Actea* in Chorea.**—Dr. E. R. Snader.—I have three pet remedies which have not been named: actea, arsenicum, and agaricus; important in the order as named. I have seen cases of chorea affecting the respiratory organs especially, cured with actea. Heart murmurs occurring in chorea are, according to some authorities, due to change in the heart muscle; I have not had any evidence to confirm this view. If endocarditis actually

occurs, it is said to be from this; but I do not believe there is any change in the muscle proper. The connection between chorea and rheumatism has interested us for a long time, and now the relationship is found to be not so common. The spasms are intermittent, but the heart murmurs usually continue.

The Remedies for Scarlatina.—Dr. W. H. Hanchett.—Belladonna seems to be the remedy mainly used; most physicians have had the best success when using it; but belladonna is not always the remedy. We are apt, even in our school, to drop into routine prescribing, and it is just as important to select the proper remedy as it is to give belladonna when it may be indicated. I frequently find other remedies called for, although belladonna may be the best prophylactic. Across the river from me is a large asylum for the deaf and dumb, supported by the State of Iowa, having generally about six hundred patients. They are interrogated, after name and address have been taken, as to the cause of deafness, and it is found that in about twenty-five per cent. of all cases, it was the result of scarlet fever in childhood. For the past five years the asylum authorities have endeavored to ascertain the school of the practitioner who treated the child for the scarlet fever. In nearly all cases it was found that the cases came from the old school. It is rare indeed that a case is charged to homeopathy.

Belladonna in Scarlet Fever.—Dr. H. C. Allen.—I want to say that this wonderful uniformity is no indication for the use of belladonna in scarlet fever or as a preventive. As Dr. Chase has said, Hahnemann told us that it is indicated only in the smooth, shining fever of Sydenham; belladonna, given by the family as a preventive remedy, in the third, fourth, or sixth potency, two or three or four times a day, is liable to get the patient and you into trouble—these are the cases which are dangerous, for the patient has a double trouble. It does not prevent the ordinary scarlet fever we are having now and it may ruin the patient. Never feed a patient until he is hungry. Let that patient alone and stop stuffing him with milk or broths or beef tea; give him water. This applies to scarlet fever, measles, typhoid, or anything else. Try this plan, and see how few com-

plications you will have to deal with and how your death rate will decrease. I wish some of our specialists in pedology would study up the epidemic of scarlet fever we are having now and tell us the genus epidemicus. I have never seen but two epidemics of scarlet fever in thirty years where belladonna was the genus epidemicus or the prophylactic remedy. Sulphur, rhus, and carbolic acid are more frequently indicated; the latter is seldom thought of by most practitioners.

The Potency.—I never think of using it lower than the 200th, either as a preventive or in treatment. Let me ask again, how many doses of scarlet fever does it require to produce the disease in a healthy child? Just *one*. And how large a dose? Did anyone ever see, smell, taste, or touch it? Never. Then what is the sense of giving the remedy every two or three hours? The patient did not get it that way. Take the teachings of Hahnemann as your guide, and you will get along better. Don't repeat the remedy while the patient is getting better; the bad complications and sequelæ will nearly always be wanting if you will give the remedy in the proper way.

Obstetrics.

Separation of the Placenta.—Dr. J. B. Custis.—Tender spots over the abdomen may mark spots of the concealed hemorrhage, and the placenta may have been separated for some time at that place. Without strong evidence, premature labor is indicated only in rare cases. The important point is the condition of the mother. If progressively anæmic, she should be carefully watched. If anæmic, with rapid increase in size of the uterus, it means hemorrhage, and the case should be promptly dealt with. I think that, if we watch these tender spots, we may be able to relieve many of these dangerous conditions. I have found evidences of clots in the placenta after delivery, which would frequently correspond with these tender spots on the abdomen. It is at least worth considering. For rapid dilatation the Barnes dilator has

never been equaled, and should not be turned down. We can dilate the uterus in a short time with it, and I have never seen a bad result following its use, where reasonable precautions have been followed. Time is an important feature, and haste is required.

Rapid Dilatation of the Os.—Dr. L. C. Grosvenor.—The finest instrument in the world for rapid dilatation is the finger; I have tried it many, many times, and it is always on hand. Now, what is the best position, for it is very tiresome. The woman lies on her back obliquely across the couch, not enough so that one side is much lower than the other. If dilatation is sufficient, kneel by the bedside with the elbows on the bed. Remember that you are to dilate easily and simulate nature; rest between pains. Dilate as forcibly as possible with the soft part of the finger, then wait, as labor pains wait, for a moment or two; then dilate again. When we have this work to do, we have first to thoroughly cleanse the hands and nails, and then cover the hands with campho-phenique: it is both an antiseptic and a local anæsthetic. I recollect being called in counsel to a case in the midst of puerperal eclampsia at the seventh month of pregnancy. The convulsions had been coming on every few hours for three weeks. Patient was thirty-seven years old. I looked the case over, and made up my mind that we must use forcible dilatation or the convulsions would kill her. We put her under chloroform, and in $2\frac{1}{2}$ hours had delivery complete, the toilet made, and the matter was a success. It is sometimes difficult to use the Barnes dilators, but the dilator I mention is easy of application.

Evidences of Fetal Death.—Dr. Sheldon Leavitt.—First, what are the evidences of fetal death? When the membranes are not ruptured and the os is not dilated, I believe it is difficult to say with any degree of certainty that the fetus is dead. The mere absence of the fetal heart sound is of small diagnostic value; I have repeatedly examined pregnant women at or near the close of gestation, and failed utterly to find these sounds, and yet have delivered a living child. The conditions which favor the transmission of fetal heart sounds to the listening ear vary in different

cases. In one case we may have the dorsal surface of the child turned forward toward the abdomen, and, in that case, very likely the dorsal surface of the child lies in close contact with the uterine wall, and the uterine wall, in turn, in close contact with the abdominal wall of the mother, giving a density of tissue favoring the transmission of sound. In another case the dorsal surface of the child is turned away, and here we may utterly fail to hear the sound of the fetal heart, and yet there may be a living child. We may learn something from the lower segment of the uterus, and, if sufficiently experienced, something from palpation of the abdomen, but we should study these cases very carefully before arriving at a positive conclusion concerning the state of the fetus. Second, as to use of the Barnes bag; I have never used it, and as a rule do not favor its use. I believe that it is extremely difficult to render such bags aseptic. It would require most careful preparation, but my objection does not lie in that direction, but I can see no special advantage in its use. If we have reason to effect delivery, it is better for us, and for the patient, I believe, to use what are known as delivery forceps. For dilatation I should prefer my fingers to any Barnes' bag. If we have time we may prepare the uterus by the introduction of a piece of iodoform gauze next the os, where it will have a tendency to soften and prepare the os for rapid dilatation. If an emergency arises put the patient under an anæsthetic, and dilate with the fingers to a point where it is possible to apply the forceps.

Chloroform in the Second Stage.—Dr. L. C. Grosvenor.—The reason why chloroform is so absolutely safe in the second stage is because labor tones up the action of the heart. In the second stage it has a nice effect in easing pain and tends to relax the rigid os. It is a comfort to have something with which to relieve pain and aid in rapid dilatation. There is no patent method of giving it. I have used it many times. I now use it in more than one-half of my cases, and they run over two hundred a year. I never carry it to a point of complete anæsthesia. I have had them under its influence for an hour and a half, and they knew nothing of what had happened when they awoke. I use a handkerchief or a napkin—never a cone, for you must mix air with

it. Never pour it on ; use only a few drops at a time, but apply often and always between labor pains.

Chloroform as an Anæsthetic.—Dr. Jas. N. Walker.—As to chloroform, I regard it as absolutely safe when used in small amounts; it takes her attention from the pains. I give it in tuberculosis, heart disease, and consumption without bad results. But while safe, it is not applicable in all cases. Why? Because we have cases where anæsthesia will defer the pains, causing them to come farther apart. As to dilatation: If the patient is on the left side, the right side of os will be dilated most, and dilatation is hardly required on that side. If the finger tires, reverse fingers as often as necessary. Shift the patient from side to side to aid dilatation. Last week, before leaving home, I saw a woman whom I delivered several years ago, and, although we had quite a fight with puerperal eclampsia, the child is living and the mother made a good recovery. She engaged me for the next confinement. When I arrived the nurse told me she had had a severe hemorrhage, and I found the patient anæmic and vomiting. I made no examination to determine whether the child was alive, but delivered as rapidly as possible; although the mother said she had felt motion when labor began, when the child was born it was dead, and had been for two or three hours. It was probably a case of premature detachment of the placenta. Now, having had puerperal eclampsia at one birth, and death from premature detachment of the placenta at the next one, what may we expect for the next time?

Puerperal Convulsions.—Dr. A. E. Neumeister.—I recollect being called to attend one case in puerperal convulsions; I tried to find out whether the fetus was alive, but they told me it was dead. I put the finger of one hand at the os and those of the other over the abdominal wall and waited eight minutes for a sign of movement. I advised that we give an anæsthetic and use forcible dilatation. I worked for a while with one finger, then with two, and finally with the whole hand, then used the forceps. The fetus was between six and seven months old, alive and crying. I washed out the uterus, and left the case doing well when I came away. The convulsions ceased for twenty-four hours.

Signs of Fetal Death.—Dr. Sheldon Leavitt.—First, as regards the signs of fetal death, the term “placental souffle” is out of date ; there is no such thing now. It was formerly supposed that the souffle heard below the umbilicus, and to one side of it, was the placental souffle ; this is found not to be the case. What is it ? The term “uterine souffle” does not explain it. I believe, and I have studied the matter quite carefully, that the sound which we always hear, not the usual attachment of the placenta, but to the right or left of the medium-line, below the umbilicus, is from the circulation of the blood through the epigastric artery—the interference with free circulation by compression of the uterus against the abdominal wall. This sound may continue after the death of the fetus, and so cannot determine its life or death.

Malt Liquors and Lactation.—Dr. L. C. Grosvenor.—There are many doctors, nurses, and mothers, and many German nurses especially, who are constantly advising the use of beer, ale, etc. In England to-day there are twenty-five thousand idiot children in the almshouses, children's hospitals, asylums, etc., because the gestating and lactating mothers are constantly taking ale, beer, and porter. In Paris, when the milk of the young mother gives out, she is advised to use these drinks. We should give these young mothers prepared milk, or other good food ; it is one hundred times as good.

Intra-uterine Rigor Mortis: Post-mortem Cæsarean Section.—Steinbüchel described a fatal case of eclampsia in a primipara, aged twenty-three, in labor at term. The case being clearly desperate, all preparations were made for *post-mortem* Cæsarean section. The fetal heart sounds became inaudible, the os externum could just admit two fingers, the head was well engaged. The mother, after tracheal *rdles* had continued for several minutes, ceased to breathe. Energetic artificial respiration was kept up for some time, and breathing was restored for a few minutes ; then death occurred, and within three minutes Cæsarean section was performed. The child was a female ; neither pulse nor respiration could be detected. Cyanosis was extreme. The body and limbs were firmly fixed in the usual

intra-uterine position by rigor mortis. The flexors of the limbs and the muscles of mastication were so rigid that it was hard to overcome their resistance. Though the infant was dead, the rigor completely disappeared after the body had been freely swung according to Schultze's method. At the necropsy of the mother, compression of the ureters was found, with long-standing right hydronephrosis, and the same condition more recent in the left kidney. There were œdema of the brain and other grave lesions. The death from uræmia was therefore easily accounted for.

Hour-Glass Contraction.—Prof. Hirst says that the so-called "hour-glass contraction" does not exist. The name is a misnomer handed down from generation to generation. There are no circular fibers in the womb to contract. The true condition is that, as is well known, the uterus contracts rapidly where the placenta is freed. And the condition of hour-glass contraction, so often described, is due to the fact that the upper part of the uterus, in which the placenta lies usually, does not contract because of the presence of the placenta. When the doctor's hand is inserted to detach the placenta he feels this contraction (which is in every way normal) and then his hand passes into the uncontracted upper segment, where the placenta lies and he is at once sure he has a "case of hour-glass contraction." Especially so if he so far forgets himself as to attempt *the withdrawal of the placenta*. The placenta should never be *withdrawn*, but should be grasped firmly after all adhesions are separated and the next pain allowed to expel the hand and placenta. If the case is urgent the expulsion may be by the method of Crede.

The census shows that seven per cent. of deaths among puerperal patients are from adherent placentas, and many practitioners regard them with horror. If hand and arm are perfectly aseptic and adhesions are pinched through by the finger nail and all clots, shreds, etc., removed, the removal of a retained adherent placenta becomes easy and devoid of danger.

Adherent placentas are very rare—retained placentas common. The Crede method promptly disposes of the latter, while the former must be separated, but should expose the woman to no added danger by such separation.

Labor.—Dr. E. P. Townsend, Medical Sentinel.—I would quote the old but not less true maxim, that “meddlesome midwifery is mischievous.”

That labor is a natural process ; that a healthy woman is as likely to be delivered *per vias naturalis* as a cow. A farmer places a money value on his cows, but did you ever hear of one spending the night, or half of it, before a calf is born, in fingering the cow's vagina and rubbing away all the lubricant exudation, or after it is born pumping her vagina and uterus full of a solution of bichloride ?

The duty of the obstetrician, who is in general practice (three times out of four an emergency man), is to always be personally clean, go to his patient, diagnose the case, and then stand by to assist nature if she needs it, but otherwise to interfere as little as possible. Theoretic principles are good to preach and teach, but after leaving his alma mater a physician's work is practical or of little use. The theory that the emptied uterus has some inherent cleansing power is undoubtedly true.

While it may not, in its semi-paralyzed condition after labor, resist the introduction of the accoucheur's hand, lumps of ice, peeled lemons, or vinegar sponges, it will almost certainly, after twelve hours have elapsed, resist the injection into its cavity of any fluid, and the patient will suffer from excruciating clonic spasms. If the germ theory of disease be true, there are no more germs in existence now than there were centuries ago. There are no statistics to show that septicæmia after labor is any less frequent or any more frequent than formerly. I therefore draw the following conclusions :

1. Sterilization in general obstetric practice is not yet a possibility.
2. Septicæmic poisoning is more frequent in the upper than the lower classes.
3. It is more apt to occur in forced than in natural deliveries.

Post-partum Hemorrhage.—*Progrès Médical.*—Tarnier's treatment of post-partum hemorrhages is merely a tampon, if the hemorrhage proceeds from the neck of the womb, the vagina, or the vulva. The important point is to locate the source. If it proceeds from the body of the uterus, it is a serious matter then,

and he applies heat in the form of hot water, but first he clears out of the uterus every trace of clot, in spite of all protests, sometimes having to clear it two or three times. If there is the slightest fragment of a clot left, the uterus is liable not to contract. Tarnier advises the use of hot water as a preventive measure when there is a known individual or family tendency to hemorrhages or uterine inertia. He has never lost a patient from a post-partum hemorrhage, and he gives no drugs except in very rare cases; he follows the hot water with a hypodermic injection of ergotin.

Gynecological Etchings.

The Peritoneum and Bacteria.—Dr. McLellan.—An incident occurred a few years ago that brought this matter to my mind very forcibly: I met an assistant of the famous Koch. Among other things, he mentioned to me some experiments he had recently made upon the peritoneal cavity. He said: "I have taken millions and myriads of bacteria, and injected them into the peritoneal cavity (of animals, understand) with the hypodermic syringe, with absolutely no effect whatever." After reporting it to Koch, he said: "Operate on your animal, and then try again." He said: "With all the care I could possibly use, I took animals upon which some experimental operation had been made. Taking simply the point of my hypodermic needle, I touched them with the bacteria of the streptococci, and in forty-eight hours every animal so treated expired." Now, he said: "That is peculiar. How do you explain that? Is it the air?" I said: "Doctor, the thing that strikes me just at the moment is this: of course the healthy peritoneum, as every healthy tissue, is competent to deal with almost any germ life up to a certain point of toleration. Now, in this handling of tissue, it is traumatized; and now your germ is operative." So from that time on, in my own practice and in any that I have had any influence over, I have steadfastly endeavored to save the tissues from handling, especially the peritoneum. If that idea is prominent in our minds, we

will many and many a time avoid the handling of tissue and bring about a better issue.

Operating Upon the Peritoneum.—Dr. Bigger.—Some person has said that, next to the brain, the peritoneum is the most important organ in the body. There are some very peculiar incidents following an operation upon the peritoneum. Why this is is largely explained when we remember the plexus of nerves which separate the capillaries which are injured and the reflexes which follow. There are one or two points that I do not quite understand. Can anyone tell me why it is that a person has that extensive thirst when the peritoneum is opened? It is said that it is owing to loss of blood, of fluids. You amputate a leg, you amputate a thigh, you do any great major operation, where there is three times the loss of fluid, but you do not get that thirst, and you can protect your patients as much as you please by filling them beforehand, by giving them large draughts, from a pint to a quart of hot water three or four times a day, with the expectation of having them saturated, and still you cut the peritoneum and there is no loss of fluid, and yet there is that great and intense thirst. I do not understand it, and have never been able to do so.

There is one point upon which I think, as a doctor, I might make a suggestion : regarding adhesions to the peritoneum, they may be visceral and they may be parietal. There is a certain fetal organ which sometimes is entirely overlooked and is a cause of this adhesion, a diverticulum which is the fetal organ of the urachus. This diverticulum is attached to the umbilicus and the other end may be floating and lodged, and will have an effect to produce a contraction which will cause inflammatory results to follow, and you will have these terrible adhesions. I think I can safely say that this diverticulum is found in *cœliac* surgery perhaps in two per cent., and must not be overlooked as a cause for this trouble. In regard to the preventing of this formidable sequence, we have found it of great advantage to follow up two or three simple devices, and one is to handle properly the intestines. Let everything be properly cleaned, and you need not hesitate to handle them. Now do not flood the abdomen in order to float them, but place the bowels where they should be—gently, carefully,

accurately, naturally; and when you have done so just pull the apron over them and do not forget that the omentum is there for protection and to lubricate and prevent adhesions; yet if you do not properly put the omentum down, you certainly would have them.

Another point is that where you have adhesions of growths, where there is a large surface denuded, how easy it is for a link of the intestine to tumble upon that surface and get adhesions and have the peristalsis stopped, and how will you prevent it? In two ways: Don't be afraid to just fill the denuded surface with iodoform. Don't be afraid to pour in a suitable amount of sterilized oil before you seal the abdomen. Now, having completed your toilet, then you must look to the action of the bowels. The *vis a tergo* and the *vis a fronte* must be looked to. Sublimate of mercury in 1-grain doses has frequently been of great advantage.

I recollect the removal of five cysts—separate, distinct, and connected more or less with the floor of the abdomen—and the adhesions were great, and two days after the operation I saw her at eleven o'clock and she looked to me suspicious. She was not then in what you would call an alarming condition, but there was a suspicious appearance. I went home and tried to sleep, but could not, and I got up at one o'clock in the morning and walked to the hospital, two miles away. I do not know what led me there except my anxiety, and when I arrived there I found a subnormal temperature with a pulse of 168, coffee-ground vomiting, cold and clammy. I opened the abdomen and with one finger was fortunate enough to raise the bowel, and it gave her such instant relief that I felt sure that we had accomplished a successful result. I remained two or three hours by her side, to watch and see that all was right. She entirely recovered, and I have always blessed my stars that I was led to walk two miles that early morning, and that I was induced to open the abdomen and raise the bowel, which gave life to the patient.

Ament Peritonitis.—Dr. R. Ludlam.—I can remember, and so can the most of you, when it was thought altogether wrong, if there was a threatening of peritonitis, to interfere with the bowels in the least. I am perfectly satisfied that thousands of women

have gone to their graves because our good old friends in the homeopathic school insisted that the bowels should be left alone. This prevails still somewhat, and it will be for the obstetricians to learn of the gynecologists as the surgeons have learned of the gynecologists. It may be a hundred years before the world realizes what it owes to the abdominal surgeon, and the gynecologist first of all.

Now, the idea that the peritoneum may be injured from without, that it may be attacked from within, ought to be borne in mind. The idea is prevalent, among the younger surgeons, that if you will have strict asepsis and not induce infection from without, that they always get well. This idea has fastened upon the obstetricians also. But there are sources of infection which we must not forget, and which we must provide against ; if we do not, then our statistics will fall back to the old statistics of a few years ago. Nothing can be more important than exciting, keeping up, and conserving the peristaltic action of the intestines. All this means a special providence as to all these conditions.

Individualism.—Dr. Pratt.—We are all born into this world with a want, and very few of us get what we want ; and it is interesting to watch the different individuals, the different manner in which they will behave under their disappointments ; some will get mad, some will get sad, some will grow hard and tough ; others will grow mild and gentle and bless the chastening hand. Why is it that one woman with laceration of the cervix will bear it with perfect meekness, and seem to dwindle and fade and finally die a little ahead of time, her whole mechanism running down and going to pieces like the One-horse Shay ? Why is it that another woman, in identically the same condition, will take a bad turn and the disease become malignant ? It is how we take things.

Local Remedies and Local Treatment.—Dr. Ludlam.—It seems to me that we might do well to settle the question, as near as may be, as to how much we may depend upon local remedies and local treatment ; how long we will be justified in using them, and how soon we must take advantage of surgical measures which are radical in their nature. Of course at this time we cannot well

be agreed ; the experience is not large enough on either side ; it is not definite enough on either side. Those who have depended righteously, properly, rightly upon homeopathic treatment internally, exclusively, have not known practically very much about gynecology. Some of those who depended entirely upon surgical means have known little and cared less for internal treatment ; so there are two sides to this question. We are at a juncture of two issues, and we want to try as far as we can, as a school of medicine, to determine the proper orbit for each branch of treatment : when medicine is suggested, when surgery is better, or both are required, to settle this question and not go too far in either extreme. There are cases which are incurable. It seems to me almost criminal to promise to cure those cases. I think we ought to try to get those who adopt internal remedies not to carry their faith too far ; they do injustice to the patients and to the school that they represent. Let us do the best we can, with all we have, for our patients—whether medical or surgical or miscellaneous—and not hold ourselves strictly to one method or the other exclusively. These statistics that these gentlemen have given us are very encouraging for operating in certain cases, if those cases can be taken early, and I think we ought to give them a good chance. It is not quite fair, I think, to hint that the gynecologists are not honest and do not desire to do the right thing. We all want to be honest, I am sure, and do the best for all concerned.

Cancer a Constitutional Disease.—Dr. Bigger.—Cancer is a constitutional disease ; it wants a traumatism to develop it, but it wants a mental shock to produce its inception, and you have got to treat it constitutionally, as well as surgically, if you want to cure it. Conservatism is to cure your patient. There is surgical disease which demands the knife ; there is medical disease, and I have seen a medicine cure absolutely medical disease which has been pronounced a cancer of the uterus by the most skilled microscopists. Still, I have very little faith in examination by the microscope as determining malignancy, because it requires an accurate adjustment and arrangement of the cells to determine whether it is malignant, or whether it is benign ; and we have some of the greatest scientists of the world as instances

of it, as in the case of the Emperor of Germany. They took a portion of his flesh and said there was no cancer, yet there was not a man who knew anything about surgery but knew it was a cancer. Therefore the microscope is not always to be relied upon.

In the City Hospital in Cleveland, which is under the care of the allopaths largely, two of the most skilled surgeons in that school told me relative to rectal diseases which were undoubtedly cancerous, that some were cured medically. I have seen two cases in North Fairfield under the care of Dr. Reed, that were undoubtedly, from my clinical experience, cancers, and in three years time I had examined those same patients, and they were under his care, and they were completely and entirely cured.

I saw a case in Akron, under the care of Dr. Childs, which was undoubtedly, clinically speaking, cancer of the uterus, which was cured by medication, in which I urged hysterectomy, but which he cured by attenuated doses, beyond any question, because I re-examined the woman and found her cured.

Now, I know doctors may be mistaken in regard to these things, but I have seen laceration of women skillfully and carefully repaired, and cancer does reappear, but there has been some traumatism, from some cause or other, which has developed it. Now, I say I believe in constitutional condition for cancer. I believe in heredity ; I believe in the heredity of scrofula ; I believe in the heredity of rheumatism. I believe the system is so constructed that, if you give it an opportunity, it will develop that which is most prominent. Let me illustrate : There are two persons under a tree, sitting or sleeping ; one escapes with rheumatism and the other with a cough. Why ? Because it is inherent and wants an opportunity to develop. There is the same cancerous condition in the system ; all it wants is an opportunity.

Pediatrics.

The Early Diagnosis of Epilepsy.—Dr. W. W. Van Baun.—So few remedies are curative that an early diagnosis is of the utmost importance. We need to recognize the condition when

we are called to see a child usually healthy, but now in convulsions, perhaps sinking to sleep and waking cross and irritable, and afterward healthy again. Then there is the condition where the child barely falls over, or where the unconsciousness is so transient as to scarcely attract attention. This emphasizes the importance of watching the children very carefully. The fact that the single convulsion is much longer, and more often associated with fever, will help us. I remember one case where a child of three years had a single convulsion. The urine was examined, and we found albumin and cylindrical casts. I thought at first it was a case of acute nephritis, but subsequent examinations showed that it was merely an acute expression of one of these attacks.

Eclampsia and Epilepsy.—J. P. Cobb, M. D.—In distinguishing between epileptic seizures and common eclamptic seizures in children, you will remember that in a majority of the eclamptic seizures, particularly those occurring after the first year of life, there is some evidence of a rachitic condition. An ordinary eclamptic seizure is, in itself, almost indicative of rachitic disturbance. It is now pretty well agreed upon that such a seizure should make one suspicious of an hereditary influence dating back to syphilis, possibly remote and showing in no other way. It has been brought forcibly to mind, in recent observations, that, in examining these children, apparently healthy, we shall usually find some of the evidences of remote syphilis.

The Complications of Pertussis.—Dr. Jos. P. Cobb.—I call this one of the most serious of all childhood's ailments, and the most neglected; yet its cardiac, pleuritic, and other complications make it one of the most difficult to treat. I should like to emphasize its tendency to develop tuberculosis and think that many latent cases owe their development to pertussis. I should like to add my experience with cresoline. I have used it in many cases and in only comparatively few has it been of value; the others went on just the same without it. I think it has been beneficial in some cases and have seen no bad effects from its use. Just a word as to the character of children attacked by pertussis. There is no system of feeding, sanitation, or hygiene

which will protect them until you take them to a country where it does not exist. I have observed this in my own experience. Many children who are properly fed and cared for will contract it. It is a peculiar disease and does not show any disposition to attack weak children : it has as much affinity for the strong child, but if the child is suffering from any catarrhal affection, it is more liable to attack, even when properly fed and cared for.

Whooping Cough in Infancy.—Dr. W. H. Hanchett.—In a child under three months of age, I consider this the most dangerous disease peculiar to childhood. I had rather treat a case of scarlet fever than a case of malignant pertussis in a bottle-fed baby. Brain troubles are one of the greatest causes of death in long-continued cases of whooping cough, and bring in a train of complications very much to be dreaded.

Stopping the Paroxysms of Whooping Cough.—Dr. J. P. Rand.—In giving an anæsthetic, where there is stertorous breathing, we put the finger behind the jaw and bring it forward so that the patient will breath quietly. If you will take a child just as the paroxysm of whooping cough is coming on and give him the same treatment, you will frequently shut off the whole paroxysm. I have taught the mothers to do this in a few instances and have thereby saved many paroxysms of cough. After the paroxysm is developed you cannot stop it. The older children may be taught to do this on themselves in the same way, when they feel the cough coming on. I cannot recollect just where I saw this treatment advised, but have seen it bring relief in a number of instances. I have never seen cresoline do any good.

Experience in Chorea.—Dr. C. T. Hood.—I have had a good deal of experience in chorea of children—over three years in our college clinic—and have made careful note of these cases. We have had from 15 to 25 cases on hand all the time, and last year had 308 cases of chorea in children. I believe a proper diagnosis essential to the successful treatment of this trouble. There are four forms. The first is the organic form, the result of trauma, or from minute emboli or softening in the motor area. This is the true organic chorea. The three more important ones are (1) Reflex chorea, coming from muscular insuf-

ficiency of the eye, from adenoid growths in the nose, enlarged tonsils, or from digestive alimentary troubles. These reflex choreas should not be taken out of school. The conditions should be removed. (2) Nutritive chorea, giving a history of malnutrition in early life; they are nervous, irritable, have had enuresis, and show various signs of chorea. They develop chorea on slight causes. Take them out of school. (3) The purely psychical chorea, arising from a fright, start, or seeing another case of chorea. The nutritive cases should be taken out of school, put to bed, and given good treatment. The psychical cases you may prescribe for for years and do no good unless you give them something besides medicine. They should have treatment by suggestion as well. Pulsatilla has helped more than any other remedy.

Rheumatism and Chorea.—Dr. J. P. Cobb.—The subject is a neglected one. I think, with the statistics in mind, that the connection between rheumatism and chorea is as firmly established as ever. In seventy per cent. of the cases there is evidence to connect it. In case of the parents having rheumatism with endocarditis or arthritic conditions in children, it is evidence of their having acquired or inherited something of the rheumatic diathesis. Some hold that endocarditis is as diagnostic of rheumatism in children as synovitis in adults. They will say, at least, that it is a frequent accompaniment. It is particularly true of cases before puberty. They are not so apt to be so in purely neurotic cases. I believe you will find that Smith, who has had many cases, says that they are part and parcel in seventy per cent. of all cases.

Infantile Scurvy and its Relation to Rickets.—Dr. Thomas Barlow, Brit. Med. Jour.—The lecturer claims that eleven years ago he presented eleven cases, which he believed to be infantile scurvy, and states that in 1873 Ingersley, a Swedish physician, suggested the scorbutic nature of one case under his care. The German school called these cases "Acute Rickets" and dismissed the suggestion of scurvy because in some cases there was no sponginess of the gums. It has now been shown that spongy gums are present only about the teeth which have

been already cut. In addition to the periosteal hemorrhages upon the long bones, ribs, skull, and scapulæ, a remarkable phenomenon about the eye is mentioned. A sudden proptosis of one eyeball is developed, with puffiness and very slight staining of the upper lid. The ocular conjunctiva may show a little ecchymosis or be entirely free. This is also due to a blood extravasation beneath the periosteum of the roof of the orbit, which is unusually loose in its attachment to the bone.

Although some of these children show evidences of mild rickets, cases of aggravated and progressive rickets, even those in which the bones are most markedly involved, do not present, during life, in spite of the cachexia, the symptoms of infantile scurvy, nor *post-mortem* the hemorrhages which are peculiar to it. Neither does it correspond to congenital syphilis and hemophilia. Whereas an analysis of the food which these subjects are found to have eaten does not exactly correspond to the ætiology of scurvy, the general symptoms are almost identical and the general lines of treatment successful in adult scurvy prove most successful in the treatment of the infant. The objection recently urged by Dr. Hoffmann that although these resemblances are very close, they cannot be considered conclusive because cases of infantile scurvy are sporadic and not epidemic, rests upon the epidemic theory of scurvy, which has been quite generally abandoned. The dependence of these cases upon their diet—prepared foods, condensed milk, sterilized milk—without enough “living food,” as Dr. Barlow calls it, and the prompt recovery upon the addition of fresh milk, beef juice, potato and orange juice to the dietary, have already been fully brought out in previous reviews in these columns

Thrush.—S. M. Christine, M. D.—The treatment of thrush resolves itself into the removal of the cause, the destruction of the germs, the application of remedies to the diseased structures, and the proper feeding of the infant.

The best wash to secure this condition of cleanliness—if this is the word—is a solution of borax alone, or with sage tea.

If the thrush has already formed, it is best destroyed by a first application of hydrozone, in nearly half strength, to nipples and mouth by means of cotton pledgets on matchsticks, care being

taken to use several with each treatment, after which they are to be destroyed. After this, the solution of borax should be applied in the same manner. The hydrozone destroys the germs and loosens the deposits; the borax assists in the process and tends to heal the tissue alterations. This treatment should be persisted in every two or three hours as long as any thrush manifests itself, or there is any danger of its re-forming. The borax solution is to be continued until the mouth is well.

Prognosis of Diphtheria.—Dr. Sigel (Medicinische Neuigkeiten), from his observations in about three hundred cases of diphtheria, concludes that the cause of the local affection is of great value in prognosis. A favorable outlook he has found to be present :

1. When the membranes appear, develop, and extend slowly. It is always favorable when it arises from a follicular tonsilitis.
2. When the color of the membrane remains white or grayish white.
3. When it is detachable without injury to the mucous membrane.
4. When the uvula remains free.
5. When the membranes one after another, or in groups, are either rapidly or slowly cast off.
6. When in nasal diphtheria the discharge is thin and watery.
7. When the glandular involvement is one-sided, appears slowly, and—even in seemingly grave cases—when the enlarged glands decrease in size.

The prognosis he would think unfavorable :

1. In rapidly developing and extending membranes; often appearing and developing in a few hours.
2. When they appear at first yellow, then rice-colored, and of a shreddy, greasy appearance and gangrenous aspect.
3. When the membranes are not detachable without leaving a bleeding mucous membrane.
4. When the uvula is attacked.
5. When, after casting off of the membranes, one or more pseudo-membranes are formed which take on the same gangrenous appearance.

6. When, with involvement of the nose, the discharge is thick, stinking, and purulent.

7. When the glandular involvement is bilateral, rapid, sudden, or which increases even with great suddenness.

8. In fetidity of the breath.

Finally, the outlook is rendered gloomy in cases which are seemingly mild, as soon as hoarseness sets in; if laryngeal stenosis complicates in cases previously mild, the prognosis is rendered dubious, and in those before grave, very bad. The same holds good after tracheotomy with high fever, bronchopneumonia, hemorrhages, emphysema of the skin, œdema of the submaxillary region, and especially when membranes have been removed during and after the operation.

A Page of Experience.—Dr. Hiram L. Chase.—I will give you a page from the experience of an old man. Many years ago I looked up belladonna as a prophylactic in scarlet fever, as proposed by Hahnemann. He told us that belladonna was prophylactic only in the smooth scarlet fever of Sydenham; where there are papular eruptions, coming out above the surface, belladonna is not homeopathic and is not a prophylactic. I use cold water; I roll the baby in a cool pack and keep him there for an hour, and then, if the rash has not come out, or is imperfect, I put him back in the pack again. Occasionally I use the enema. I have no trouble as a rule. In some cases, however, and in other fevers, the patient is dead from the start. I have seen these cases, too, with sadness and sorrow; every man who has practiced thirty years has seen them. I remember the case of one little child, living over two miles from any other house, taken with convulsions followed by profound stupor. The throat was perfectly black, and convulsion followed convulsion in spite of all I could do. All the flesh between the sterno-mastoid muscle and the chest sloughed away. The child could not swallow any nourishment, but lived for seventeen days. I sincerely trust that none of you will ever have such an experience. The child was poisoned through and through, and medicine was of no avail. I had one case where the bones of the ear came away. I have been in practice for fifty years, have seen all sorts of cases, and am not afraid of the use of cool water.

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HOW MUCH SHOULD BE DONE AT ONE OPERATION.*

BY

SIDNEY F. WILCOX, M. D.,

Consulting Surgeon to the New York Hospital for Women, and the Brooklyn Memorial Hospital for Women and Children. Professor of Surgery in the New York Medical College and Hospital for Women.

DOUBTLESS many of the members of this society are frequently in a quandary as to how much operating, or rather how many operations, should be done on one patient at a single sitting. This applies particularly to gynecological work, because when one starts in to repair damages he finds a number of things which require attention. In some cases he may find only a lacerated cervix, as the result of parturition, but in many others he will find a laceration of the perineum with perhaps an accompanying

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rectocele, and maybe a cystocele of greater or less degree. There may be also some small carunculi or hemorrhoids, and as likely as not a clitoris with adherent hood, and so on. If the operator wishes to save the time and money of the patient and to avoid the distress of mind with which she always anticipates the taking of an anæsthetic—he may be tempted to do everything at once.

The writer has been in this position many times, and the temptation has been to do as much as possible at one operation for the reasons above mentioned. I have often repaired the cervix and perineum, and remedied an extensive cystocele at the same operation, and perhaps done a little trimming besides. But lately I have begun to question whether this is the best method, all other things being equal.

This doubt arises not from the fact of bad results, for my results have been uniformly fairly good, if the patient had the proper care and exercised proper precautions after the operation, but in reviewing the results of fifteen years' experience, I am inclined to think that in some ways the results were better where the operations were divided up and done in two sittings.

In the first place, taking the operation on the cervix. My experience shows that the most perfect results have been obtained when silver wire sutures were employed and removed after union was complete. Silver wire cannot be used for the cervix conveniently when the perineum is repaired at the same time. I say *conveniently*—for while it may be used, it is difficult to remove the sutures on the eighth or tenth day, on account of the difficulty of getting at them with the perineum freshly healed. If they are left *in situ* until the perineum is completely healed, silver is not superior to chromicized gut, or silk worm-gut or even silk.

When the perineum is operated upon at the same time with the cervix, it is best to use some form of absorbable suture, such as sterilized catgut, chromicized catgut, whale

tendon, or kangaroo tendon. These may be used with good results, but in my opinion the results cannot be depended upon to be as perfect as when the silver is used and removed at the proper time. In the first place I believe silver wire, if properly prepared, to be the least irritating of all suture material, and, when practicable to use it, the safest. Thoroughly aseptic fine black silk ranks next, and the animal sutures last. With the majority of surgeons I have been using animal sutures extensively during the last few years, and for all sorts of wounds, both internal and external. I have always used the best which could be obtained, and I think I am as particular as anyone in regard to having the conditions for asepsis as perfect as possible. But in spite of all this care, I have had imperfect results in healing wounds which could not be attributed to anything else than the animal sutures or ligatures. I think it may be claimed, as a general rule, that animal sutures are less dependable than silver wire.

If one uses chromicized catgut for the cervix with the idea that it may be left in until it is finally dissolved, he is likely to find that the sutures remain in much longer than they are required, and that they act as irritants, producing deep sulci in the cervix, which may eventually smooth over, but which are not as satisfactory as one would like; especially as they have to be filled with granulation tissue, which will later take on the character of a cicatrix and act as an irritant to the cervix. I have found chromicized gut sutures in position at the end of a month, long after their term of usefulness had ended.

Plain sterilized catgut is uncertain as to duration and is apt to be absorbed *too* quickly, and the edges of the wound separate in consequence. Kangaroo tendon may have the objections of either chromicized or plain catgut, according as it is prepared. It is supposed to last for a long time, but Dr. Wm. H. Bishop told me of a case of his where it was absorbed in a perineal wound in a week. One thing

which seems to me probable is that the absorption of the animal suture does not always depend so much upon the ligature itself as upon the activity of the tissues. It may be that in some persons the tissues have greater power of absorbing or dissolving foreign organic substances than others. In other words, a greater phagocytotic power, if I may so put it. This would account for what is otherwise often unexplainable in regard to the retention or disappearance of animal sutures. Silver wire, properly prepared, is quite unirritating. My method of preparing it is to first clean it with strong aqua ammonia, to remove the sulphide and make it bright, and then to boil it thoroughly in a five per cent. solution of carbolic acid. It is then kept in small glass jars, immersed in equal parts of pure carbolic acid and glycerin. This may seem to be an unnecessarily complicated method, but one has no trouble with wire prepared in this way, if it does not become contaminated at the time of using.

I also think that the rigidity of the silver wire is an advantage, for the parts are held more firmly in apposition without being any tighter than with the more flexible sutures. This applies particularly to perineal wounds, and is a matter of some importance, as absolute rest and perfect apposition are the great *desiderata* for the accomplishment of perfect healing.

The foregoing is the gist of the whole argument. There are often many reasons why everything should be done at once, but, as before stated, I should prefer to operate on the cervix, and perhaps remove the hemorrhoids or caruncles at a first operation, and leave the perineum and cystocele to be done later, at the convenience of the patient and operator.

HEMORRHAGE INTO THE SAC DURING THE
NINTH MONTH.

BY

LAMSON ALLEN, M. D.

MY reason for bringing this subject to the consideration of this representative body is its rare interest and great importance. For whatever endangers the life of the *fetus in utero*, must engage our most earnest attention as practicing physicians; and whatever concerns the clinical history of pregnancy is of deep interest to all who practice the art of obstetrics. The life of the fetus may be endangered and its nutrition cut off by certain discharges which originate in the cervix or in the womb. These discharges may involve the double risk of its intra-uterine starvation or of precipitating its premature delivery or of both. Among these discharges it is rare to find such a case and such a termination as I am about to describe.

On the 26th of May, 1895, a note was sent me by Mrs. D., saying that she was having an offensive vaginal discharge, and, if I thought necessary, to call immediately at her home. She had passed her expected date of confinement about two weeks, so I answered her call at once. At my visit she said she had not felt motion for two weeks. She had been in apparent good health during the last three months, as she had during the whole of her pregnancy. She knew of no reason why the movements should cease, for she could give us no history of trauma or fright. Neither had there been any pain of any kind, or any sign of shock. And the only thing that seemed in any way wrong was the ichorous discharge with the extended time of gestation. She was a primipara.

On examination I found the fetus dead. The os was not dilated, but the cervix was soft and pliable. We at

once proceeded to induce labor, and by afternoon of the next day labor was progressing normally.

At 7 P. M. of May 27 the os was fully dilated and I burst the bag of waters. Instead of amniotic fluid, we had over two quarts of unclotted blood of the odor of fresh blood. Labor was normal, occiput presented in the right anterior position. The child was undergoing mortification, and death had evidently taken place at the time motion had ceased. The child was perfectly developed and there were no signs of injury to, or defect of, the placenta.

Concealed accidental hemorrhage (for that is the proper name for this condition) is not a common affection. So far as we know the causes are limited; the most common cause is trauma, and the blow occurs over the seat of the placenta usually. Other causes may be irregular or partial contraction of the uterus, causing separation of different portions of the placenta; rupture of the utero-placental vessels; or laceration of a placental sinus.

Probably the most hidden cause of concealed accidental hemorrhage is the toxæmia of pregnancy. Perhaps no one substance is especially dangerous to the pregnant patient, but the gradual accumulation of the nitrogenous waste, the potassium combinations, and the animal alkaloids produce a condition of toxæmia, the symptoms of which are first observed in a disordered state of the nervous, digestive, and excretory systems. Mental emotion is another cause. Again the detachment of the placenta may be due to general disease, such as variola, scarlatina, typhoid fever, or to local disease, nephritis, or acute atrophy of the liver.

When we consider that during the last three months of pregnancy the growth of the uterus is such as to weaken the connection with the placenta, we wonder that there are not more of such cases instead of less.

In accidental hemorrhage, the placenta is attached to the uterus at its normal site.

The symptoms of concealed accidental hemorrhage are

shock, which is greatly out of proportion to known hemorrhage, acute pain, anæmia, and excessive distention of the uterus. Sometimes the distention of the uterus marks the seat of pain. The flow of blood is seldom apparent, but when it is, it may amount to anything from an ooze to a gush. But this symptom is not to be expected in such cases, and when it does occur is only affirmative.

Accidental hemorrhage may occur before or during labor. In the latter case the hemorrhage ceases during the pain, because the pressure from the presenting part obstructs the flow, thus making it a diagnostic feature.

In the treatment of these cases we must be guided entirely by the circumstances of the case. If the woman has not advanced far in her pregnancy and the hemorrhage is slight, as shown by the symptoms and signs, and there is reason to believe that placental detachment has not taken place to any great extent, then give her perfect rest in the recumbent posture, allay all excitement or anxiety, administer cool drinks and the properly indicated remedies. Withhold as long as possible in compliance with safety the use of tampons or other irritating appliances, which will be sure to precipitate labor.

On the other hand, where the flooding is apparent or excessive, danger is imminent, the woman is at her full term, and the hemorrhage is accompanied with pains, or is without pain; or where the above or any former measures have failed, and labor is apparent, then the purpose of our treatment must be to bring on or increase labor, to induce uterine contractions, and secure the expulsion of the child, as far as is consistent with safety. And this is best done by rupturing the membranes.

By rupturing the membranes, egress is given to the liquor amnii, and the excessive strain on the uterine walls from within is removed. This expedient also helps to produce vigorous expulsive action. While this action plugs the os by forcing down the fetus, it also compresses the placenta

between the uterus and child, thus closing mechanically the mouths of the bleeding vessels. Such is usually the happy termination of the case for the mother, though the child is almost always dead. Goodell's celebrated collection of one hundred and six cases gives a mortality of fifty-one per cent. for the mothers, and ninety-four per cent. for the children.

Should, however, all the above measures fail, then we must resort to forcible dilatation of the cervix, preferably with Barnes' bags, and complete the delivery by turning, by the bimanual method, or by the use of the forceps.

After the delivery of the fetus, the case must be managed as in any other case of labor with its complications.



THE RELATION OF THE SUBPERITONEAL TISSUES TO THE SURGERY OF THE AB- DOMEN.

BY

HOMER I. OSTROM, M. D.

AS a matter of convenience, the present discussion of abdominal surgery will include also the surgery of the pelvis; both regions, though anatomically distinct, being physiologically one in their relation to the peritoneum.

All pathology must have physiology for its foundation. Without a knowledge of the normal action of organs, it is impossible to judge of their abnormal action. In like manner our success in dealing with disease will depend upon the degree to which we invoke the assistance of health.

The surgery of the abdomen is no exception to this general rule. I desire to call especial attention to one factor in abdominal surgery, one which I regard as among the most important: the treatment of the peritoneum and the subperitoneal tissues.

In regard to the peritoneum we note, *first*, that its endothelial covering, like the epithelial covering of the skin, serves as a protective envelope, but, if I may be allowed the expression, the true function of the peritoneum lies in the subperitoneal tissues. This structure, as a whole, without going more fully into its anatomy, is composed of elastic connective tissue, containing a liberal provision for arterial and venous circulation. It also contains lymphatic vessels and glands, and is supplied with nerves from both the spinal and sympathetic systems.

The true function of the endothelial cells, aside from that of secreting serum, which, it will be remembered, possesses chemical as well as lubricant properties, thus

becomes apparent, viz., to protect the subperitoneal tissues, which from their highly vitalized structure are susceptible of injury, and, still more important, are, when exposed, capable of absorbing materials with which they are brought in contact. In other words, the endothelial layer, when intact, permits only as much absorption as takes place through the lymphatics which open on the free surface of the serous membrane. This is a physiological process, and one of nature's reserve forces against the encroachment of disease. For the glands connected with these lymphatics possess the power of digestion and are thus able, to a certain extent, to alter the character of substances subjected to their influence. Noxious material introduced into the abdominal cavity becomes through the agency of the lymphatics of the subperitoneal tissues—which seem to be principally situated in the vicinity of the pillars of the diaphragm—innocuous; the chemical process which they there undergo depriving them of their virulence.

With the destruction of the endothelial, or protective layer, the physiological action of the peritoneum is interfered with. Absorption no longer takes place through the lymphatics, but the material that lies in the abdomen is brought in direct contact with the open mouths of vessels, and through them conveyed unchanged into the general circulation. It is this condition that we encounter in all abdominal operations, and our recognition of it, and our ability to cope with it, will greatly influence our successes, or our failures, in this department of surgery.

With these data of the peritoneum before us, and in this I include the subperitoneal tissues also, it is evident that a principal feature of abdominal operations must have regard to the treatment of this great serous sac and its underlying structures.

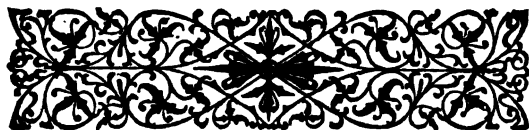
The ideal abdominal operation would preserve the continuity of the peritoneum. This, of course, is impossible. Our substitute, therefore, for the perfect method will be to

leave the peritoneum at the conclusion of the operation as nearly intact as possible; to cover over the subperitoneal tissue; and thereby prevent absorption save through the normal channels, the lymphatic vessels.

In my vaginal hysterectomies, I am careful to close all connective-tissue spaces by bringing the layers of the broad ligament together, as well as the peritoneum and the vaginal mucous membrane. Though I have abandoned the use of clamps in this operation, save under exceptional circumstances, one of their great advantages was in closing the subperitoneal tissues of the broad ligament, by holding the peritoneal layers of the broad ligament in contact.

Also in my abdominal hysterectomies, which I now perform by total amputation, I do not consider the operation completed until peritoneum is everywhere in contact with peritoneum, and until all subperitoneal tissue is protected from intra-abdominal influences.

A like principle actuates all my abdominal work. Every pedicle within the cavity is covered with peritoneum. Every solution of peritoneum made is carefully repaired. Thus the field of operation becomes extraperitoneal, and the protective function of the peritoneum preserved.



TYPICAL SKIN DISEASES OF CHILDREN.

BY

SAMUEL N. WATSON, M. D.

THERE is no product of the physical laboratory of nature more delicate of texture, more sensitive to irritation, or more easily injured beyond repair by neglect, than the skin of a child. The skin diseases of childhood may therefore be classed and treated by themselves, inasmuch as the tissue which they affect is in a somewhat different developmental stage than the same tissue as it appears in one of maturer years. Histologically, its structure is of course about the same, and, therefore, the natural divisions of skin lesions may be followed in speaking of them in general, viz., the arrangement according to the depth of tissue involved, beginning with the macule, and following on through the papule and vesicle to the pustule. But inasmuch as the infant's skin represents a somewhat differently functioning structure from the adult skin, certain preliminary considerations must be made before taking up certain of the pathological lesions in their normal order.

An infant, just after birth, presents the well-known red skin caused by the distended capillaries; also, generally, the coating of vernix caseosa, which is the protection of the delicate epiderm from the desiccating influences of the amniotic fluid. It is evident, therefore, that the infant is born with highly developed sebaceous glands, which at times may produce a secretion, long after their normal functioning period, which it is difficult to get rid of, and this excessive sebaceous secretion—really a perverted function, and not a proper skin disease—is the first subject we shall notice. Its principal occurrence is upon the head, where it is known as *seborrhea capitis*. There sometimes gathers upon the heads of children, especially those who

are not well cared for, a collection of crusts of a brownish yellow color, caused by the excessive secretion of the sebaceous glands of the scalp. There is a superstition among some of the nurses of the older type that it is not safe to remove it, but no such superstition should be allowed foothold in the doctor's mind. The presence of these crusts simply means *dirt*; they should be loosened with a little warm sweet oil, and then removed with warm soap and water; and an ointment of simple composition like the ung. aq. ros. of the U. S. P. applied to prevent their future accumulation. The scalp of a child should be at all times as clean as soap and water can make it.

It has already been noted that at birth the child's skin is exceedingly sensitive to external influences. It will show variations in color in direct proportion to this sensitiveness, and also in proportion to the greater or less amount of irritation to which it is exposed. There is generally a period of what sometimes appears like a genuine desquamation, in which the delicate layers of the epithelium are thrown off in considerable quantity; and it is often several weeks before the normal infantile condition of the skin is reached. In most cases the hyperæmic condition of the skin spoken of fades away, constantly and gradually, until in about a week the normal rose-leaf tint is established. There are, however, cases in which this hyperæmia persists for some time, and in which the surface is an almost uniform dull red: a condition which is known as *erythema neonatorum*. Care must be exercised in these cases in diagnosing accurately so as to exclude all possibility of erysipelas or scarlet fever, both of which diseases have occurred in the first week of infant life. There are usually no constitutional symptoms in connection with *erythema neonatorum*; and beyond great care in the use of soap on the skin, no especial indications for any treatment are present.

These considerations, while not pertaining to distinct

pathological lesions, yet suffice as an introduction, and show what a very sensitive tissue is the infant skin. Of proper dermal lesions there is perhaps none more common, nor any that plays a more important part in child life, than this one of erythema, whose consideration we have just begun. Its simplest form, scarcely a true erythema, is the condition known as *intertrigo*, which is really little more than an exaggerated hyperæmic condition of the skin, occurring principally in the folds, especially about the groins, and then caused most generally by friction, and by the irritation occasioned by the continued presence of wet napkins. Sometimes, however, it is more severe, and is often the prelude to an attack of eczema. The simple intertrigo requires no especial treatment beyond care in keeping the skin dry and clean, and dusting it with some simple powder.

There are forms of *erythema*, however, much more serious than that just mentioned; and without paying much attention to the varied names by which they have been described, we may class their various lesions under two general heads, viz., *erythema simplex*, or the congestive type; and *erythema multiforme*, or the inflammatory type. The simple erythema is often little more than a reddened condition of portions of the skin, of the macular order, and is a local hyperæmia of nervous origin. It is the form that results from local irritation, or is symptomatic of the acute exanthemata, or is most commonly seen as the surface manifestation of some internal irritation caused by parasites, heat, digestive disturbances, and the like. The erythema of the inflammatory type is more than a local irritation of the macular order, and is protean in its lesions. They may be represented by maculo-papules, vesicles, and sometimes even bullæ. In color they vary from a bright red to a purplish red, and the more delicate the skin the more vivid the eruption. The eruption may affect any part of the body, but has a predilection for the backs of the hands and the feet; and may be accompanied by fever, malaise,

slight nausea, and loss of appetite. In general, however, these especial symptoms are not present. The treatment of all forms of erythema must be symptomatic. Here, as in all the ills that flesh is heir to, *Tollite Causam*—Remove the cause—if it can be discovered, is a rule of first importance.

The value of a simple dusting powder, in all these local irritations of childhood, cannot be overestimated; and while there is no better powder made than that of Reed & Carnrick of New York, yet, inasmuch as some of the patent powders may be of infinite harm, it may be well for the doctor to be provided with a simple formula for a powder of this kind, which he can always commend and can always be obtained. I know of no better than the simple preparation R. Zinc-oxide. 3 ij. and amyli tritic. (powd. starch), 3 ij. mix. Internal medication in the form of aconite, belladonna, rhus, and mercurius will often be of value. In all these cases, where an external lesion as symptomatic of a distant irritation is present, too much stress cannot be laid on the classic precept of "Rest."

It is a wonder how some infants ever escape being walked to death, and fed to death, and talked to death, and joggled to death, and generally worried into their graves. The infant faculties are not prepared for all that is put upon them; and if a child is ailing, the thing of prime importance is rest; rest its stomach, rest its nerves, rest its brain.

We pass now to another familiar skin lesion of childhood, *urticaria*, commonly known as hives—again a symptomatic lesion of a distant irritation, sometimes of purely nervous origin, but generally produced by irritation in the gastro-intestinal tract. It is a disease which may end in a few days, may last a few weeks, or may become chronic. Essentially, however, it is an acute affection, and when its well-known lesions of wheals and spots, somewhat raised above the surface, with apparently great itching and burn-

ing, appear, attention should at once be given to diet to determine what has caused the outbreak, that a repetition of it may be avoided. Some simple article of food, with regard to which the child has an idiosyncrasy, will generally be found to be at fault, and must be carefully avoided; for while the disease is not dangerous *per se* it causes a great annoyance and suffering to the child; and in the sensitive nervous condition of infancy may cause other nervous and functional disorders, as reflexes, which are far more serious than the original affection. Diet should first be looked at, less irritating clothes should be worn next the skin, the bowels should be kept free, and the dusting powder already mentioned should be used. These measures for comfort, accompanied by the exhibition of our invaluable remedies, urtica, apis, calcarea carb., or rhus, will speedily put an end to the trouble. Urtica is the typical remedy; calc. carb., will be found of great value in the white nettle rash of calcarea children with its intolerable itching.

Another common disease of child life is *herpes*. Here we have a more distinct skin lesion than any yet considered; beginning with a little group of vesicles on a reddened base, sometimes spreading, sometimes stationary: exuding a sticky fluid, when scratched, and accompanied with some itching and burning; self-limiting, and non-contagious. A most common form of it is that known as herpes labialis or facialis, the common cold sore, or fever blister, having its favorite location about the mouth or lips, involving generally the vermilion border; again spreading over the cheeks or nose or chin, and sometimes attacking the mucous membranes of the mouth. It is a frequent concomitant of many acute febrile disorders, and occurs also in connection with derangements of the digestive organs. It may be diagnosed from eczema by the larger size of its vesicles, by the absence of any intense continued itching, and by its natural tendency to recovery; the whole process being

generally finished in eight or ten days. We have a sovereign remedy for this disagreeable affection in nat. mur., which I have used in the 6x trit., and in the 30x dilution, with marked results; and have never found any other remedy necessary. Another form of the disease that is by no means uncommon is what is known as *herpes zoster*, or shingles. It affects the back, chest, or sides; is unilateral, and is generally accompanied by fever, malaise, and considerable pain along the intercostal nerves. The eruption is vesicular, and its unilateral character should be carefully marked; it runs a definite course of about fourteen days; its vesicles become pustular, and form scabs, and finally disappear without any trace being left. The disease is probably neurotic; and is worth mention, for diagnostic purposes. Its treatment is essentially medicinal, and while rest and diet should be enforced, the materia medica is our stronghold. Here mezereum is the typical remedy, with graph., thuj., and mercurius as excellent substitutes.

I pass now to the hydra-headed plague, which often baffles the physician's utmost skill, and plays a greater rôle in infancy and early childhood than in any other period of life, *eczema*. Its cure is so difficult that it cannot but be looked on as a grave affection, and yet at times it responds in the child so speedily to intelligent treatment as to make the careful physician seem to the grateful parent almost as a worker of miracles. Skin lesions may generally be diagnosed by classification and exclusion, dependent upon whether they are macular, papular, vesicular, or pustular, as they are in general constant in their inclusion in some one of these divisions. Eczema is not. It is macular, papular, vesicular, and pustular; each by turns and all together, backward and forward and sideways. There is nothing that is constant about it except its itching, its ugliness, and its pertinacity. Usually the first question that the practitioner will be asked concerning it, when called to see a case, is, "Is it contagious?" and in this connection may

be mentioned the only alleviating feature of this plague. It is, fortunately, *not contagious*. Pathologically speaking, it is a form of dermatitis, acute or chronic, though very often the latter; manifested by macular, papular, vesicular, and pustular lesions, often followed or accompanied by fissures, with an exudation that may be serous, plastic, or purulent; terminating, (as to give the thing due credit, it sometimes does) in the formation of crusts and desquamation. *Ætiologically*, eczema is always symptomatic of some irritation, which may be local or may be distant. Eczema may be idiopathic in the sense of being consequent on some direct or mechanical irritation of the skin; or it may be symptomatic of some distant irritation; such, for instance, as irregularities of the digestive or urinary organs. Functionally eczema represents failure in nutrient nerve force, the skin bearing the brunt of the failure. From this consideration, it may be seen that it is not an error to consider eczema hereditary in many cases; what is inherited, of course, being nothing positive, but rather that deficiency in vital energy which manifested itself in defective dermal nutrition in the parent, and is followed by the same negative condition in offspring. Miller of Pennsylvania gives the history of a family in which the eczematous diathesis seemed plainly marked, as the disease itself appeared for four generations in his practice; and other records of a similar character are extant. The external appearance of eczema is extremely varied. As has been said, the disease is often chronic and the physician frequently has no opportunity of examining it in its early stages, and must diagnose it by its history, as given by the parent, who, full often, has never noticed or has forgotten the very things you wish to know. In the majority of cases, local congestion is the first thing noticed, with itching. This sometimes gives place on scratching to a moist, excoriated surface, which may be associated with desquamation. At times the disease will be entirely papular, and no vesicles, nor any

history of them can be found. Again the vesicular form may be the turn the disease takes, and then with the scratching come moist sticky exudations, which sometimes degenerate into purulent effusion, and which always end in thick crusts. When these crusts are removed, the underlying surface is found moist and reddened. The repeated removal and renewal of these crusts are the characteristic features of this form of the disease. And in general, in all forms of the disease, there is constant itching, and with children, just as constant scratching. The disease terminates with a disappearance of the exudation,—if there be one,—the formation of scales on a dry and shining surface, and a gradual return to a normal condition. A case from a recent clinic in the University Hospital in Boston will serve well to show the variety of the manifestations of the disease. It was in a little girl five years old. The right arm and leg showed the moist, red, oozing eczema; on the backs of the hands were reddened spots showing the macular form; on the left leg were numerous collections of slight elevations of a pink color, exhibiting the papular form, while on the face and scalp were seen thick crusts, and at their edge minute whitish dots, showing the vesicular and papular forms. As has been said, these forms may all appear singly, or, as in this case, all may appear on the same subject. If the typical lesions were regular or constant, and if the itching and scratching did not so often change the external appearance, diagnosis might be easier than it often is; but as the disease appears in practice among children, it cannot be said that the diagnosis is easy, the books to the contrary notwithstanding. When it comes to treatment, the old advice must again be repeated: *Tollite causam*—Remove the cause. An advice more easy to give than to follow in the case of young children. But full often some local or distant irritation will be found on careful examination, the removal of which puts the system in condition to respond to the help of appropriate medical

treatment. A case occurred in my own experience two years ago, where an obstinate and distressing eczema existed in a child of fourteen months. Careful inquiry elicited the fact that the baby had not been weaned, that the mother was not furnishing proper food, that a condition of chronic diarrhea was present as well as the skin disease. Sulphur appeared to be the appropriate remedy. The baby was put on Mellin's food; the remedy was given. The diarrhea stopped in forty-eight hours, and the eczema disappeared in three weeks. Treatment therefore involves search for and the removal of the cause. If the cause is not found, provided it be not purely functional, medicine seldom produces lasting cures. The next thing is, relief and rest; and the two go together, and both in large letters. Itching and scratching will often put a cure beyond reach. For the relief of the itching and the general softening of the surface in the simpler cases there is nothing better than a plain ointment of oxide of zinc.

R	Ung. zinci oxid.....	} aa ʒj
	Lanolin.....	
	M.	

Spread upon bandages of soft cotton cloth, which at once soften the inflamed skin and protect it from scratching. In case the whole head is involved, a mask and cap should be worn, to keep the ointment in contact with the skin and to protect it from the restless hands of the child. The same of the body. As long as the lesions are extensive the child should be kept quiet in bed, and its feeding should be carefully guarded, that no dietetic complications may prejudice recovery. The things of prime importance in treatment of this disease in children are relief and rest. Rest for the nervous system is imperative, and that means not only a cessation of the itching, but quiet of the muscles and brain. Those who have seen the havoc that a bad case of eczema will sometimes work in the development of a child, and the scars that it will sometimes leave behind it,

will not regard these instructions as of little importance. Objection will often be heard from some doctors to the use of external adjuvants in the treatment of these diseases, and captious criticism from others; but I must agree with Dr. Strong of New York, one of the ablest dermatologists of our school: "I fail to see why a diseased and irritated surface should not be protected and mollified when this state is due to an internal cause, just as well as when it arises from a burn or some other external irritation."

In the selection of a remedy the good prescriber has a grand scope for the exercise of his genius; and genius it may well be called, for the genius of the disease must be sought for. There are few indications of the local sort that may aid the physician in choosing his remedy in a case of eczema.

Arsenic stands well at the front as a sovereign remedy in skin diseases of all kinds, and is especially indicated in eczema of the papular form, and in the later stages of chronic cases, where crusts are scanty or lacking; where the skin is dry and scaly; and where the itching and burning are a marked feature. It is especially useful in eczema of the face.

Clematis and viola are remedies that seem adapted best to the moist and crusting forms of the disease, especially as it appears upon the scalp.

Dulcamara and graphites point to the form of the disease in which there is a profuse serous exudate; dulc. showing an especial preference for the face, and graphites for the fingers and ears.

But, in general, the best prescription is the diathetic one. Study the diathesis of the child, and do not stop with the child, but take into consideration the physical habit of the parents. It is in this field that we find our best allies in remedies like sulphur, hepar, staphisagria, mercury, calc. carb., and lyco. Nowhere will close prescribing render more beneficent results to the patient, and more grateful returns to the doctor, than in the eczema of children.

The outlines of a few of the commonest dermal lesions of children have been briefly touched upon, not exhaustively,—which time would forbid,—but as a sort of *catena* to link together certain plain precepts as to the consideration and treatment of skin diseases in general. Time also forbids that I should attempt to cover the ground any more thoroughly, and, therefore, many of the other proper dermal lesions of childhood must be left untouched, together with all that are ætiologically of a parasitic nature.

Certain general precepts may be added in conclusion :

1. *Diagnosis*.—For purposes of diagnosis an inspection of the whole surface of the child should be made in all cases that appear at all obscure ; and, in many more cases than with adults, will diagnosis be difficult, on account of the various developmental changes in the progress of the lesions. Again, it should be borne in mind that no single dermal lesion—macule, papule, vesicle, or pustule, crust or scurf—makes it justifiable for us to decide whether an especial disease is present or no. The same cutaneous lesion may appear in almost any disease, and it is the combination of dermal lesions, the *tout ensemble*, the history, and the diathesis which make the entire picture of the disease that will justify us in making a positive diagnosis.

2. *Prognosis*.—Should always be guarded. The physician is always on the safe side in skin diseases who does not promise too much in the way of a cure. He may cure, he often will ; but his reputation is not hurt if he cures when he has only promised to do his best ; and it is hurt when he promises a cure, and his very best is, as it too often is, only failure.

3. *Ætiology*.—The cause of about one-half of all skin diseases is DIRT, somewhere, in some form. In a fair percentage of the other half the cause is local in some form of irritation, parasitic, or other ; and in the rest the cause is generally distant, and the skin lesion reflex.

4. *Treatment*.—These considerations make cleanliness an

item of prime importance in treatment. A good, pure, fine soap, and plenty—and that should be emphasized—plenty of clean warm water, applied not too often, but daily, are most invaluable therapeutic adjuncts. Next comes *rest*—rest for the tired nerves, rest for the tired muscles, rest for the tired stomach, rest for the tired brain, and also rest for the irritated nerves of the skin by emollient treatment, and the prevention of irritation will often suffice to work a cure.

And last, but not least, the needed drug, carefully selected from our full *armamentarium*, and intelligently exhibited, will complete the grateful task, and will make sure that cure which, when once accomplished, will add both to the spread of the doctor's fame and the favor in which he is rightly held.



CÆSAREAN SECTION: RECOVERY.

BY

G. FORREST MARTIN, M. D.

I WAS called March 14, 1896, to see Mrs. K., aged twenty-eight, mother of four children. History, briefly stated, was this: had been "flowing" considerably, off and on, for thirteen months. For past three months this had been much worse and came away in gushes of blood whenever she stood on her feet. Considering it a menstrual trouble she had never consulted a physician until above date, when she fell upon the floor from exhaustion.

Examination showed cervix raw, ulcerated, and bleeding at the slightest touch; os open about half an inch; on either side, the region of broad ligaments was occupied by a hard mass, fixing uterus firmly into pelvis; rectum and bladder also drawn into the same mass; the pelvis "floored," as it were, with a hard, unyielding, immovable, cancerous mass—the cause, as one vessel after another was eaten away, of the repeated hemorrhages.

Abdominal palpation showed uterus high up, size of full term, and occupied by a living child. The "motion" though feeble, was unmistakable. Here was a dilemma! The pelvic floor was impassable. The growth was too far advanced, and too hopelessly adherent to bladder and rectum, to offer any hope of removal. Labor I believed imminent. The patient was weak, bloodless, and exhausted. A terrible death in labor seemed to be her fate.

I sent patient to Lowell General Hospital to be ready for any emergency, put her to bed, had foot of bed elevated, fed her on Bovine and Malted Milk, at two-hour intervals, and gave chininum ars. 3d, internally. At the same time H_2O_2 was used to the os, and everything possible done to increase her strength. She rallied perceptibly for a week,

and the hemorrhages were held in check. About March 22, contraction as if in labor came on, and bleeding once more appeared. The same, March 23, and I ordered patient prepared for operation, which I performed the following day, assisted by Drs. Gage and Leland of the staff, and Dr. Burnham, the house physician.

The anæsthetic used was chloroform one part and ether three parts. The abdominal incision extended from umbilicus nearly to pubes. Bleeding points were clamped, peritoneum opened, and an examination hastily made. Secondary involvements were too extensive to offer any hope from a complete uterine and ovarian extirpation. Decided to save the woman from the labor, and give her her only chance of a few months of life.

Flat sponges of gauze were packed about the wound, the uterus drawn up into it and incised. The placenta was found attached in front. No time was lost, but incision made right through it, the hand plunged in, child's two feet and thighs drawn into the wound, quickly followed by the other parts. Sweeping the hand around in the uterine cavity the placenta was quickly removed, and sponges, dipped in hot sterilized water, took its place. This brought about firm contraction and checked the hemorrhage. Deep stitches of sterilized silk were used in the uterine wall; finer stitches of the same drew the peritoneum over the cut. The same sutures were used in the abdominal walls, in two layers, and an abundance of dry dressing applied.

Drainage was secured through the cervix, by a tent of sterilized gauze, inserted from above before closing the uterine wound. The growth was now curetted from cervix, as much as possible, and the vagina packed with strips of gauze. The latter was removed the following morning, and the cervical drain the third day. The abdominal dressing was removed the 29th, and a union by the first intention shown, except in one stitch-hole, where a little suppuration took place.

The patient made an uninterrupted recovery—highest temperature 101° , highest pulse 124 (it was 108, from anæmia, on entering the hospital). Went home April 16, and has gained steadily, been out to ride twice, and suffers little up to this date (May 20).

Of course the patient cannot last long with such a disease, but she can be made comparatively comfortable, and her family are now prepared for what must come.

The peculiar features of this case are that such a patient could become pregnant in the first place; that a cancerous growth should progress so far with so little pain; that pregnancy should be so masked by a hemorrhage, and that an intelligent patient should mistake her size for a "bloating" or "collection of waters;" and lastly the recovery, when the whole system was so drained and vitiated.

The child was fully developed—nails, hair, genitals, etc.—apparently about eight to eight and a half months old, but very poorly nourished. It lived but about one hour after delivery.

June 8, 1896: patient about same, only a little weaker. Sloughing continues through cervix and vagina, terribly offensive, and the cachexia becomes more marked. Patient able to sew and read some, otherwise about the same.



INFANTILE DIARRHEA.

BY

CHARLES D. CRANK, M. D.

THERE is no subject within the domain of the general practitioner with which he is more familiar than that of infantile diarrhea. It would appear almost superfluous to invite your attention to this condition; indeed I would not venture to do so, were it not for the continued frequency and unrelenting death rate of this great scourge. It must be evident to every practitioner that infant diarrhea is neither a simple nor a single problem the solution of which is to be found in the indicated remedies alone, but that it consists of a number of factors, some of which are not understood or made available in staying the current of this great destroyer. The question is as broad as it is important—too broad to be covered by the limits of this paper. I can only refer to a few practical features which are claiming the attention of pediatricists the world over—features of primary importance because they deal with the possibility of prevention, which exceeds in practical worth the probability of cure. Ever since the attention of the fraternity was arrested by an array of statistics showing that more than two-thirds of infantile gastro-intestinal troubles and three-fourths of the accompanying mortality was among the bottle-fed, it has been untiring in its efforts to account for these remarkable facts.

The fraternity has reached the almost unanimous opinion that it is a question of dietetics, and that the difference in favor of the breast milk was principally owing to its being practically sterile. However much we may differ in our views respecting bacteria—their mission for good or evil—research both in the clinical field and in the bacteriological

laboratory clearly demonstrates that abnormal bacteria are found in the intestinal tract, and, under certain conditions, are inimical to infant life and health. So well established is this fact that it is leading to a nosological reclassification based upon such ætiological considerations rather than upon pathological finding or supposition as heretofore.

Cholera infantum is now recognized under the term of "acute milk infection," and entero-colitis as "subacute milk infection," it being claimed that practically these conditions never occur with infants at the breast. The question at once arises, "Are all forms of infantile diarrhea of abnormal bacterial origin?" We do not know positively that any form of diarrhea sustains a constant relation to any variety of bacteria, neither do we know the exact nature of the morbid processes which take place in the intestinal tract. We are lamentably ignorant in exact knowledge upon many of these points, but they are within the range of human knowledge, and our hope lies in this frank confession of our ignorance.

The researches of Escherich, Bagnisky, Jeffries, and others encourage the growing belief that pathogenic bacteria and infantile diarrhea sustain relation to each other as cause and effect; some of the exceptions being the direct result of overfeeding, improper or irritating foods, wherein the primary looseness is salutary rather than otherwise.

Without entering upon further consideration of the relation of bacteria to infantile diarrhea, let me call your attention to two practical points: First, the increasing prevalence of artificial or substitute feeding, second, the principle of rendering milk sterile.

To-day it is the exception rather than the rule for the mother to suckle her own offspring. And the indications are, says Rotch, "that substitute feeding will increase rather than decrease as civilization advances"; and unless something is done to avert results, the slaughter of the innocents will continue in increased proportions.

Let me ask, Why are mothers so willing to escape this all-important and necessary duty? Let the new woman answer, and proceed to take an active interest in the societies forming in the East, which have for their purpose to encourage and facilitate maternal lactation in all classes of society, having especially in view the prevention of infantile mortality.

But the family physician cannot escape his responsibility. Let him seek to remove the cause or causes which render artificial feeding necessary. Let him proclaim the truth that there is no sufficient substitute for the breast of a healthy mother; that the nursing bottle is full of trouble and may acquaint her with grief.

But it is claimed, and rightly too, that some mothers are not able to suckle their offspring, and it can as truthfully be said, some mothers ought not to do so. We will not stop to discuss the why or wherefore or the extent to which this may be remedied. Recognizing the fact, let me briefly refer to the process which has for its object the rendering of milk sterile. I do not deem it necessary to defend the principle involved or the benefit to be derived from its application, but some confusion has arisen as to the use of the term as well as to the change which has attended the application of the methods.

Prior to the scientific researches of Hueppe in 1859, Pasteur in 1851, and Lister in 1873, the true cause of the souring, fermentation, and putrefaction of milk was unknown. Chemical means were resorted to, to prevent the souring, or, if slightly turned, to render it palatable. These men first brought to light the truth that these changes would not take place if the milk was kept for a time at boiling temperature. This degree of heat destroyed the influence which impaired the wholesomeness of the milk. This influence was found to be of a micro-organic nature. No fact in science is better established than this. Quickly following this announcement came the sterilizer. Experience soon

demonstrated that milk subjected to this degree of heat, (212° F.) would undergo such changes as to render it unsuitable for infant nutrition.

Pasteur found that a temperature of from 140° to 160° F., suddenly brought down to a temperature of 50°, was all that was necessary to destroy such bacteria as threatened the purity of the milk or the health of the child.

Koçh and Klein corroborate this statement, and say further, that at this temperature the nutritive properties are not disturbed. This method is termed Pasteurization and has superseded that of sterilization.

Now comes Leeds with the statement that the tendency is toward a still lower temperature, and, still later, that milk filtered through cotton and scalded before feeding will protect an infant against all ordinary pathogenic influences and furnish a palatable and nutritious food. Or, according to Seibert, simply filtering through cotton will accomplish all that is desired.

Probably no new suggestion was ever more favorably received and more generally acted upon than that of milk sterilization. The mother was led to believe that as good a nutriment as her own had been provided and all that was necessary was to sterilize the milk, place the rubber in the baby's mouth, and the infant would do the rest. The sterilizer was introduced into the nursery and into public institutions. But infantile diarrhea continued and the death rate was not reduced.

"To knowledge must be added understanding, and to understanding, wisdom."

It was true that milk, to be perfect food, must be practically sterile. But it was just as true that it must be assimilable. Sterilization accomplished the former but failed in the latter, and the failure has so prejudiced the community that there is great danger of the infant losing the benefit of the principle altogether. Experience in sterilization developed at least four important truths: First, that milk heated above a certain temperature so alters

the digestive principles as to render it unfit for infant digestion and nutrition. Second, that the inner relationship of the several constituents of cow's milk is not understood. Third, that the mission of bacteria and the relation of varied forms of micro-organic life to the intestinal tract are not understood. Fourth, that the solution of the feeding problem lies in a closer study of nature's processes and the better understanding of her provisions for her little ones.

The rendering of the milk sterile is not regarded as a cure-all in intestinal troubles, but as a preventive and a prophylaxis, and as such will soon be recognized by every State board of health, and it will become the duty of dairy commissioners and milk inspectors to protect the public by bacteriological as well as chemical examinations. It is the duty of every physician to awaken to a full significance of the interest involved; to realize that in it lies the progress of pediatrics.

It is not claimed that bacteria are the only source or cause of infantile diarrhea. It is not claimed that Pasteurization, sterilization, or any other method or process is infallible or to be advised to the neglect of any other hygienic principle. It is not claimed that Pasteurization solves the great problem of substitute feeding. But it is claimed that over eighty per cent. of infantile bowel troubles are preventable. It is claimed that the principal source of trouble is involved in questions of infantile dietetics and substitute feeding. It is claimed that the principal remedy lies in the use of human milk, and failing to secure that, in the approximating of cow's milk to the composition of human milk as nearly as possible. It is claimed that Pasteurization is one—and a very important one—of many efforts to that end. It is claimed that purity of cow's milk is the first desideratum, and for that purpose Pasteurization is of primary consideration.

Did time permit, I would claim that as an ætiological factor in the production of infantile diarrhea next to quality of food is that of quantity. If it be a task to arouse an intelligent interest in the subject of milk infection, doubly hard is it to awaken a generous mother, a thoughtless nurse, and the busy practitioner to a proper understanding of infantile gastric capacity, its use and its abuse.

A RECURRENT UTERINE FIBROID POLYPUS.

BYFRANK S. ABY, M. S., M. D.

OPERATION: Was called March 7, 1896, to see Mrs. —, aged forty-four. She reported a sharp uterine hemorrhage on March 4, since which time she had remained quietly in bed, the hemorrhage had continued, somewhat abated, but nothing but blood had passed from the vagina. Reported the last menstrual period in November, 1895.

Of course, pregnancy and abortion was the snap-shot diagnosis. A vaginal examination revealed to my exploring finger a semi-solid, rounded body, about the diameter of a billiard ball, presenting at the ostium vaginae. Sweeping the finger about this, I detected the intra-vaginal portion of the cervix and this body protruding from the cervical canal; cervical canal widely dilated. Exploring further, the finger could be swept, inside the cervical canal, entirely around this body. The body filled the palm of the hand.

An attempt to determine the parts of the supposed embryo resulted in complete mystification. The exploration was continued up into the uterine cavity as far as the finger could reach. Gentle traction failed to extract the body. The plot thickened. Evidently this was not the product of conception. Finally the idea of abortion was abandoned, and was supplanted by a concept of polypus.

The uterus was now forced down into the pelvis by the left hand upon the abdomen, and the right index finger was introduced far into the uterine cavity. A pedicle was found on the posterior wall of the uterus, apparently an inch above the internal os. This was dissected away by

the index finger, and the body was removed. No hemorrhage followed—in fact, the manipulation of the uterus caused the hemorrhage to cease. Thus the operation was performed without the aid of any instruments except those provided by nature.

Description.—The polypus was $3\frac{1}{2}$ inches in length, about 2 x 2 inches at the presenting end, in shape and size somewhat resembling the normal uterus. The presenting end was covered by a slimy mucous membrane, the sides were roughened by the dissections of the index finger. It was immediately split lengthwise, and revealed a cystic cavity, lined by a smooth membrane. Three blood clots, the largest the size of a hickory nut, were split open. The blood clots were quite solid. No part of the tumor even remotely suggested that it might be the product of conception. The diagnosis was uterine fibroid polypus.

Examination, and Curettement.—After examining the polypus, the uterus was again forced into the pelvis by the left hand placed externally, and the right index finger introduced through the patulous cervical canal into the uterine cavity. At the fundus the exploring finger encountered several bodies, each apparently the size of a hickory nut. These were supposed to be other polypi.

I had no instruments with me, not even a pocket-case. The following day I returned, prepared to clean out that uterine cavity. The cervical canal was still patulous, so that the finger readily passed into the uterine cavity. With Holbrook's douch curette the cavity was thoroughly curetted. A quantity of semi-solid débris was removed, some portions being as large as a filbert. The hemorrhage was quite free, but not alarming. The cavity was dried, carbol-iodine solution applied thoroughly, and the uterus packed with iodoform gauze.

History.—Two days afterward, after some considerable effort, the following history was obtained: Mrs. —, aged forty-four years, menstruated first at twelve years,

menses regular, but excessive; married at eighteen; mother of eleven children; had one miscarriage at third month.

I. Last living child born April, 1889. No doctor present.

II. Gave birth to twins in May, 1890.

III. In November, 1890, had a very severe uterine hemorrhage. The attending physician experienced great difficulty in checking the hemorrhage, among other expedients raising the foot of the bed. He considered it a desperate case. He made careful and repeated efforts to diagnose the cause of the flow, finally stating to the husband that all he could say was that it was a "hemorrhage."

In December, 1891, gave birth to a dead child at full term. Labor tedious; expulsive pains ceased.

V. In October, 1892, another severe uterine hemorrhage occurred, and another physician removed something from her uterus. For several months previous to this experience she had suffered severe menorrhagia and metrorrhagia, as well as excessive and offensive leucorrhea. The body which was then removed was "bad-smelling, and looked like a lump of flesh." Mrs. C., an experienced matron, saw this body, and said at the time that it did not in any way resemble a fetus. Mrs. — was not convalescent for a long time after this date, October, 1892. The attending physician would make no statement as to the condition of affairs. The menorrhagia was almost *nil* for several months after this date, then began to increase gradually, until the next flooding.

VI. In June, 1893, another uterine hemorrhage occurred, and the same physician who attended in October, 1892, was called. As near as the patient could remember, she went through an experience very similar to that of October, 1892.

VII. In January, 1894, there was a similar attack. Another physician was called. He did not make a vaginal examination. Called it a miscarriage, and went away.

VIII. In July, 1894, patient was in Wisconsin, when a sharp uterine flow began. Patient remained quiet, and about ten days after first appearance of hemorrhage, while sitting on a chamber to urinate, there slipped from her vagina "a bad-smelling body, half as large as my hand, covered with matter." The menorrhagia and metrorrhagia continued until November, 1894, when the menses ceased. Since then leucorrhea has been excessive.

IX. As stated before, on March 4, 1896, a sharp uterine hemorrhage set in, and on March 7 I was called, and removed the fibroid polypus. At each menstrual period since November, 1895, patient had a "dirty, dark discharge."

Summary.—Tabulating this history, we have the following outline of the case :

I. April, 1889, child born.			
II. May, 1890, twins born.			
III. November, 1890, first uterine hemorrhage.	13 months after	I.	Probably first polypus.
IV. December, 1891, still birth.	6 " "	II.	
V. October, 1892, tumor removed.	13 " "	III.	
VI. June, 1893, tumor removed.	10 " "	IV.	" second "
VII. January, 1894, uterine hemorrhage.	8 " "	V.	" third "
VIII. July, 1894, tumor expelled.	6 " "	VI.	" fourth "
IX. March, 1896, tumor removed.	6 " "	VII.	" fifth "
	18 " "	VIII.	" sixth "

From the evidence in hand it appears that the polypus which I removed in March, 1896, and which I have preserved in alcohol, is the sixth in the series of uterine fibroid polypi which this woman has been producing. I have searched the literature on this subject, and have failed to find more than a sentence here and there indicating the possibility of the formation of a series of uterine polypi. From the digital intra-uterine examination made immediately after removing this polypus, I am certain that others were well started above the pedicle of this one. Whether others will form is a point which I will watch with much interest, and promise a further report if another polypus develops.

ECZEMA.*

(Syn. Milk crust, moist tetter, salt rheum.)

BYA. M. LINN, M. D.

ECZEMA is classified under the vesicular form of eruptive diseases, and is either acute or chronic. It is a non-contagious, inflammatory disease of the skin, very common, and exceedingly variable in character, and constitutes rather more than one-third of all skin diseases. It may appear at first as an erythema, a vesicular, papular, or pustular eruption, or several of these forms combined, and is attended with infiltration, exudation, and accompanied by redness and itching.

The disease is not heralded by noticeable systemic disturbance. The patient may note only the erythematous blush or slight burning, or see numbers of vesicles closely crowded upon a limited surface. These, when ruptured, exude the characteristic, sticky, honey-like serum, which dries into crusts and scales. When the scales are exfoliated they leave a reddened, irritated surface, upon which they are speedily reproduced by the exudate.

Jackson names the following series of symptoms characteristic of eczema, three or more of which will be found present in every case: viz., redness, itching, infiltration, tendency to moisture, crusting, or scaling, and cracking of the skin. These are landmarks which serve to guide us with reasonable safety in pronouncing a diagnosis.

Eczema may affect all parts of the body, and presents itself in varying forms and types. According to location it is named eczema capitis, when developed upon the head;

* A paper read before the Bureau of Pedology in the American Institute of Homeopathy at Detroit, Mich., June 17, 1896, by A. M. Linn, M. D.

eczema manuum, when located upon the hands; eczema faciei, when located upon the face, etc., etc., etc. And again, according to type, it is named eczema simplex, eczema rubrum, eczema pustulosum, etc., etc., etc.

The affection usually forms patches, which shade off into the healthy tissue. The patches may be small, or nearly the entire surface of the body may be affected. From a mere point the disease spreads with more or less rapidity. It may involve a small or large surface, may remain stationary or tend to recovery, or may develop into the chronic form.

Children are particularly liable to eczema. It is one of the tortures of childhood. Out of five thousand cases tabulated by White, the ratio under ten years of age is as follows :

Within the first year of life,	569	cases.
Within 1 and 2 years of age,	286	"
Between 2 and 3 years of age,	280	"
Between 3 and 4 " " "	198	"
Between 4 and 5 " " "	144	"
Between 5 and 6 " " "	118	"
Between 6 and 7 " " "	93	"
Between 7 and 8 " " "	76	"
Between 8 and 9 " " "	66	"
Between 9 and 10 " " "	60	"

The statistics tabulated by Bulkley do not vary largely from the above, and both prove conclusively the susceptibility of children to this affection. It is therefore a pertinent inquiry, Why the liability of the young to eczema? The thought naturally suggested is that diathesis must be an important factor in its production. Outside of the French school, however, little consideration is accorded diathesis, nor can it be asserted with any assurance that dyscrasia is an important factor in its production.

Eczema affects every grade and rank of life alike, enter-

ing with equal readiness into the hovel and the palace. The ill-conditioned and the well-nourished are apparently alike susceptible. Authors assign as causes depraved conditions, constitutional dyscrasias, irritation of trophic nerves, filth, dentition, unsuitable food, irritating clothing, etc.

That which depresses the vitality and renders it incapable of resisting the onslaught of disease predisposes to eczema. Among such causes may be enumerated digestive ailments, whether of the stomach or in the nature of an intestinal irritation, or any derangements of assimilation; also disorders of the liver and the kidneys.

As an impoverished condition of the blood predisposes to this affection, such conditions as chlorosis and anæmia become causative factors. Also among reflexes such as nerve irritation, derangements of the trophic nerves, vascular disturbances, the derangements of teething are all recognized as exciting causes. An analysis of these symptoms will give us some knowledge of the ætiology of the disease.

Nervous symptoms are prominent in childhood. The development period in childhood is most susceptible to eczema. During this period, rapid changes are occurring in the nervous system and in nutrition. The fact that eczema is sometimes relieved when nerve irritation is removed indicates this, at least, as a factor in its production.

The apparently healthy child in his luxurious home has the ill-appearing eruption as well as the little waif in the alley. If coarse, rough clothing produces the disease in the case of the latter, as is argued plausibly, it certainly cannot be a factor in the former case, where the child is wrapped in softest wool.

If bad food causes the trouble in the little Arab of the alley, where nourishing food is a rare article, it certainly is not the cause in the case of little Cræsus, where both nurse and doctor scrutinize with scientific care every morsel of

his sterilized food. If neglect and filth produce the disease in the neglected waif, which indeed cannot be denied, how do they enter as active factors where the atoms of dirt are religiously excluded in the case of the other? If cold and exposure, as alleged, are productive factors in the case of the alley waif, and it is impossible to prove the contrary, how can they be exciting causes in the instance where little Cræsus revels perennially in tropical warmth? Atmospheric changes which chill the little Arab aggravate his eczema, but the pampered child of luxury in the palace, although he does not feel the chill, is worse also.

Taking the average of cases, the chances are that the little alley waif will have a profusely fluent catarrh, and that little Cræsus will scratch with eczema. The one has catarrh of the skin and the other of the mucous membrane.

Although eczema constitutes rather more than one-third of all skin affections, and manifests itself in multiple forms and phases, it has as yet proven a hopeless task to try to divide it. Like the primary elements in chemistry, it is incapable of division. The types are defined, and vary considerably in character, but they all marshal under the general term, eczema.

This is pre-eminently the day in which the disease germ flourishes, and no affection is regarded as so unimportant but an effort is made to discover its specific bacillus.

Some theorists—Una, among others—have asserted that eczema is due to a specific germ. The truth of the assertion is not yet demonstrated.

It is well to study the effects of eczema upon different temperaments. The average observer has noticed that in scrofulous individuals there is a tendency toward the pustular type, and usually a free formation of pus in chronic cases. This fact is amply verified in the profuse mucopurulent secretion in cases of eczema capitis and faciei in scrofulous children. In the nervo-bilious patients, the subject becomes irritable, and in rheumatic and gouty subjects there is a tendency toward inflammatory action.

We are indebted to Kippax for a demarcation of the stages of eczema. The first, or stage of invasion, is marked by a redness, infiltration, and the formation of vesicles. The second stage is characterized by the escape of the characteristic, sticky, honey-like exudate from the denuded surface, and the formation of scabs and crusts. The third, or chronic stage, is marked by cracks and fissures, and dry flakes and scales. The division is not altogether fanciful.

Acute eczema has distinctly marked symptoms. The stage of congestion is followed by inflammation, redness, and exudation, and accompanied by itching, burning, and smarting. There is swelling and consequent hardening of the skin, with functional disorder. Little systemic disturbance is manifest, or, at most, restlessness and moderate febrile movement. Soon the exuded serum from the cutaneous vessels lifts the corneal layer at numerous points, and the little vesicles appear over the site of the inflammation. Instead of vesicles, papules or pustules may appear, or if the effusion be profuse, the epithelial layer may be raised, leaving the denuded corion exposed and weeping.

In children of all ages the itching provokes vigorous scratching, which ruptures the vesicles. The effused serum is thick and honey-like, often irritating the adjacent parts, and staining and stiffening the linen. Whether the vesicles be broken or left intact, the contents dry, forming thick brownish or greenish scabs. Time and the disposition to remain constitute the dividing line between the acute and chronic forms of eczema.

The acute gradually merges into the chronic case without marked variation of symptoms. It simply gets neither better nor worse, and thus indicates that it has come to stay. In the chronic case there is usually more swelling and hardness of the skin, and the surface frequently becomes fissured. The burning and itching are severe, and are a source of ceaseless annoyance to the little patients. The papules, vesicles, and pustules continue to pour forth their exudate

and form thick, heavy crusts. The site of chronic eczema is usually the head, the flexor surfaces of the joints, the genitalia, and parts most richly endowed with sweat glands.

When the inflammation is located upon the scalp, it constitutes *eczema capitis*. The effused serum mingles with the dirt and hair, sometimes covering a large part of the head, and forms into dense heavy crusts, popularly called scald-head. In neglected cases, the crusts may become from one to two lines in thickness, and form a most offensive, loathsome spectacle.

The definition of eczema affords the reader a generous hint to its pathology. It is a catarrhal inflammation of the skin, and is analogous to the similar affection of the mucous membrane. The inflammation, even when long continued, is superficial, and involves only the papillary layer of the skin and those above it. Even when chronic, it does not tend to destroy or permanently injure the deeper layers of the cutis. Quoting from Kippax, p. 92, "Eczema is due to faulty innervation, by which cell proliferation and capillary congestion, with their consequences, are produced. The papillary layer is its principal seat and the *modus operandi* of its development is as follows: an exudation of serum takes place from the congested vessels, which floats the oversupply of new cells, and the two push on to the rete from the papillary layer, separate the cell elements of the stratum malpighii and stratum lucidum, and uplift the cuticle so as to form first papules, and then vesicles."

An erythema only becomes an eczema when it is succeeded by sufficient exudation and scaling to distinguish it as such and shows a tendency to recur. It is more a difference in degree than in the character of the affection. The initial symptom is a reddened patch of varied size, marked by some itching, burning, and tingling, and fading imperceptibly into the surrounding healthy tissue. According to the violence of the attack, the discoloration will be faint or distinct, and the accompanying symptoms will be mild or

severe. The color may be uniformly pinkish, or become red or yellowish. The surface gives a distinct sense of hardness and roughness to the touch.

This form is usually circumscribed in extent, manifests a decided tendency to recur, and is most frequently located upon the face and neck. After frequent recurrences, it inclines to remain in the chronic form.

Eczema papulosum, as indicated from its name, is characterized by the development of papules in predominance, although vesicles and pustules may obtain also. The papules are thickly studded over the surface affected, and vary in size from a point to a mustard seed. In color they vary from light to dark red, and are either discrete or coalescent. The papules are sometimes surmounted by minute vesicles. The patches vary in size and form. It chiefly affects the extremities, and is not common to the period of childhood.

In eczema vasculosum, the vesicle is apparent immediately upon the onset of the disease. If the attack develops abruptly, it may be accompanied with marked fever, thirst, restlessness, headache, and derangement of the bowels. There is distinct sense of heat and burning at the point of eruption. Its appearance, preceding the development of the eruption, is usually red, but may vary through many shades from pale to deep red. Over this discolored surface, minute, thickly crowded vesicles appear. They coalesce, rupture, and discharge a clear, sticky, honey-like serum, which develops into greenish crusts. When the crusts are removed, a raw weeping surface is exposed. In the process of repair, the exudation ceases, the crusts which are formed gradually become thinner, and when they are exfoliated, they reveal a hyperæmic surface beneath. As improvement goes on, the skin gradually assumes a healthy hue. This is the most common form of eczema and in its range is likely to cover considerable areas on any part of the body.

Eczema pustulosum affects the scrofulous, debilitated, and cachectic individuals, and is the most frequent type occurring in children. Its favorite location is on the face and scalp and behind the ears.

Its development may be either from vesicles or pustules, which usually occur, densely crowded, upon the affected surface. They rupture and pour forth their secretion, which dries into thick greenish crusts. The itching may be mild or severe. When the sensitive surface is scratched it readily bleeds, and the blood, mingling with the discharge, makes the crusts dark or black in color. When the crusts are removed, an irritated, moist surface is revealed bathed in pus. The discharge is often ichorous, and injures the healthy tissue with which it comes in contact. In obstinate and neglected cases the dirt and hair mingle with the excretion, and form a dense mat, which is both loathsome and offensive. *Eczema pustulosum* is an obstinate form of this disease, and shows some systemic involvement in the swelling of the adjacent lymphatic glands. Likewise, the progress toward recovery is slow, and relapses are prone to recur. In the progress toward recovery, the profuse secretion gradually subsides, the scales and crusts are less rapidly formed, the succeeding crop becoming thinner. The attendant swelling gradually disappears, and after considerable time, the skin assumes its normal hue.

Eczema squamosum is but the vanishing stage of this disease. It is characterized by the exfoliation of flakes and scales of the epidermis. The exfoliation is distinctly visible in the erythematous form, and obtains during the chronic stage of all the other varieties. There is persistent infiltration and tumefaction of the skin.

The latter is somewhat firm and inelastic, and is liable to crack and fissure, particularly when about the flexures of the joints. The return to health is somewhat tedious, and injuries to the skin are likely to provoke a recurrence. Beneath the flakes the surface is dry and hyperæmic. The

corneal layer of the cutis is "imperfectly reproduced, and is exfoliated again and again." When the disease covers large surfaces, considerable quantities of the scales are cast off. This condition obtains less frequently in children than in adult age.

Other diseases may be coincident with eczema, and will need to be differentiated. It is particularly important that an accurate distinction be made between eczema and the syphilides. Bearing in mind the landmarks as indicated by Jackson, the diagnosis is comparatively easy.

In acute eczema an early recovery may be safely promised. The chronic form may persist for years in spite of the best treatment. In this form it is very intractable. Burnet does not promise his patients a cure under twelve months. Continued relapses under the best treatment are unfortunately the rule. In general, it may be safely said that cleanliness is of prime importance in the treatment of eczema. Dirt and filth stand obstinately in the way of a cure. Topical applications of olive oil, lanoline, vaseline, etc., may be used to soften the crusts and facilitate their removal. They also serve the excellent purpose of excluding the air and allaying the itching. Care should also be exercised to prevent injury to the abraded surfaces. Astringent ointments are of very doubtful utility, and their use is attended with some danger.

I will content myself with naming the following remedies for your study in the treatment of eczema: arsenicum, ammonium carb., calcarea carb., antimonium crud., clematis, calcium sulphide, dulcamara, graphites, hepar sulphur, lycopodium, mercurius, mezereum, nat. mur., petroleum, psorinum, rhus tox., staphisagria, skookum chuck, tartar emetic, thuja, viola tricolor.

CHOREA.

BY

C. A. WEIRICK, M. D.

A DISEASE characterized by irregular spasmodic movements of voluntary muscles. It develops most frequently in early life, ninety per cent. of cases beginning between the ages of five and twenty years, and eighty per cent. between five and fifteen years. As most cases occur between ten and fifteen years of age, the changes incident to puberty might be considered a factor in its development, but such is not thought to be the case. The disease has existed in infancy at birth in case of a choretic mother, though it is rarely found under four years of age. A few cases are reported after the age of seventy-five. A majority found to have the disease after thirty years are not having primary but recurring attacks. It is therefore usually developed in youth.

While chorea itself may not be hereditary, yet nearly half the cases have inherited a predisposition to nervous diseases. Children with precocious intellects, having great animation, restless dispositions, and general susceptibility of the nervous system to be unduly excited, are predisposed to this disease. More than two-thirds of the cases occur in females.

Rheumatism at one time was supposed to be a common cause of chorea, but its production by this cause is now considered doubtful. While wet, changeable weather is a potent factor in the production of the former disease, the latter is very little influenced by temperature, moisture, and barometric changes, although two observers report a greater number of cases occurring in months having the largest number of cloudy days. Mental strain—especially fright, anxiety, excitement, and over-study—causes chorea.

The above are the usually accepted causes of chorea. But they are common in the ætiology of many affections. The inherited nervous conditions not only predispose to chorea, but to other diseases of the nervous system which may cause functional and even organic changes in various organs. The age at which it is most frequently developed, the psychological conditions, and even the sex, are all important influences exerted in producing many other diseases.

The following, I think, briefly explains why the same exciting causes produce chorea in one person and different diseases in another. The predisposing causes of disease render some of the anatomical elements, tissues, or organs of the body unable to sustain themselves while performing their normal functions; hence, without exciting causes, disease may develop, though more slowly and later in life than when influenced by the latter class of causes. Then if the patient be predisposed to neurotic diseases, and if certain portions of the nerve-centers be susceptible—probably some parts of the cortex of the brain—chorea will be developed. The exciting causes of disease may all be designated as abnormal stimuli of the reflex arc. If the stimuli be different in quality, though applied to the same afferent nerve fiber, phenomena of different diseases will be produced; if the power of the transferring center be less than that of the transmitting fibers of the arc, then a neurotic disease of central origin will be developed from the same kind of stimulus that would produce a disease of an entirely different nature in the tissues supplied with the fibers of the arc; if the center of the arc be perfect, then abnormal stimulation will produce peripheral disorders.

The symptoms are familiar to all physicians. At first there is noticeable not a lack of co-ordination, but an exaggerated motion of the one intended, with sometimes either a premature or delayed relaxation. The earliest symptoms are usually observed in the extremities.

There is no regular interval between the movements, but they become more and more frequent until in very severe cases they may be constant. When fully developed, voluntary and co-ordinate motion is impaired by involuntary twitching movements of sets or groups of muscles. The use of the arms is impaired, walking interfered with; momentary attacks of double vision due to unequal spasm of the muscles of the eyeballs; speech difficult, sometimes impossible; and in very severe cases the patients have been thrown from bed and the spasmodic movements have been so severe as to break the teeth. Because of the impossibility of continued muscular action, the patient cannot hold anything. The respiratory muscles may be involved; resulting not only in irregular breathing, but increased and irregular action of the heart.

The position of the patient does not affect the pulse as much as in health. One or both sides may be affected, or it may go from one side to the other.

Chorea is a painless disease, the sensibility usually remaining normal; when increased, there is as a rule some complication, often either hysteria or rheumatism. Convulsions seldom take place in this disease, although they do occur.

Maniacal chorea sometimes is a form developed in females, usually at puberty or during pregnancy. With this phase of the affection the choreic movements are decreased or entirely subside. This form of mania is self-limited, running its course in about two weeks; leaving the patient for a limited time dull and indifferent, with occasional hallucinations; exceptionally, however, the mind is permanently weakened, even when caused by pregnancy.

When uncomplicated, there is usually no pathological change discoverable by the naked eye in the nerve centers, and in many cases not by the microscope. If the attack be severe, there may be microscopical changes in the blood vessels and in the nerve cells; hyperæmia, plugging of

small arteries, and when complicated with endocarditis, frequently extravasation of blood in brain and spinal cord.

Cardiac complications are often developed, especially endocarditis, in the severer attacks. Over ninety per cent. of fatal cases have structural changes of the heart. Endocarditis is found more frequently in secondary than in primary attacks.

In the urine there is an excess of urea, phosphates, and oxalate of lime. By the alterations in the urine an effort has been made to show the relation between rheumatism and chorea. In these two diseases the pigment in the urine is the same; but different from that found in any other nervous disease.

Duration is very variable, usually from a few weeks to six months, although it has continued from childhood to old age. In a report of nearly four hundred cases, one hundred and forty-seven did not exceed one month, fifty-seven per cent. lasted between one and three months and six per cent. exceeded three months. It is liable to recur, particularly in females, at an average interval of one year. If a period of two years elapses without an attack the danger of reappearing is usually overcome.

Prognosis.—The tendency is toward recovery of the attack, with liability to recurrence and development of neurotic functional troubles. About three per cent. of cases not pregnant are fatal. In pregnancy it is very serious, the mortality being over twenty per cent.

Treatment.—The causes of functional nervous diseases are common to so many of them that it is impossible to consider the preventive treatment of chorea separately.

I believe that it is a functional trouble and that the pathological conditions found after death are due to complications. Autopsies often reveal no pathological changes in the brain and spinal cord. Hence, because of the difficulty of thoroughly restoring the nervous system to the same degree of vitality as before the attack, the necessity

of proper management of those children predisposed to derangements of the nervous system. Many attacks occur in children having very bright, active minds, which, because of the injudiciousness of parents and teachers, are given mental burdens entirely beyond their physical ability to endure; resulting in functional nervous diseases manifesting themselves by two opposite conditions, viz., either an over and irregular action, or under or indolent action of the cerebro-spinal system. The former gives rise to the restless, spasmodic movements, including chorea of early life and the neuralgic and neurasthenic diseases of middle age, with the consciousness of a growing incapacity to perform the usual amount of mental work. The ineffectual effort to overcome this last greatly aggravates the existing trouble, increases the danger of complications, and, of course, lessens the chances of perfect recovery.

The second condition shows itself by a different class of symptoms; both, however, indicating a debilitated nervous system.

Not infrequently does the child of the family that promises most intellectually turn out to be the dunce, because the pride of those having charge of him leads them to overburden the mind and ignore the physical development. In this downward course chorea is one of the many diseases produced.

As a prophylactic measure, therefore, a child's education should not be intrusted alone to parent and teacher, but also to competent medical supervision.

This is the era of the germ theory in medicine; it might be appropriately called the microscopical era in diagnosis. The present is also a period in which some neurotic diseases are very frequently found, and others are increasing, especially insanity, which has among its causes chorea. The bacteriologist, with the aid of the microscope, aided by municipalities and State, has discovered the germs peculiar to many diseases, and sanitary boards have promptly taken

measures to prevent their spread ; but these special guardians of the public health have not yet given sufficient attention to the prevention of nervous diseases, the foundations of which are laid in youth.

The public schools afford a field for systematic investigation to determine what influence they exercise in producing impairment of the nervous system. From time to time a greater number of branches taught has been added to the curriculum and the standard of proficiency raised, while the time required to accomplish this added work has not been proportionately increased, if at all.

Does this higher standard of education in childhood and youth result in a proportionately elevated standard in middle life without detriment to health? Is the mind as alert and vigorous, then, as it was before the increased burdens of youth were added? These questions can only be answered after the study of observations that have extended over many years, and which have been carefully made and recorded by medical doctors. Sanitary boards should examine the course of study in the public schools, and be vested with power to modify it in the interest of health.

Fright is given as the active cause of many cases of chorea, hence should be guarded against ; and, of course, children should not be frightened for amusement. But in cases from this exciting cause there is a previously weakened nerve power, which probably determines the degree to which the same cause of fright may affect the organism. In one case it may be but a momentary feeling of fear, with slightly accelerated pulse ; in another an involuntary stool, or an attack of chorea, or a tonic spasm, or death. Often fright develops chorea from what had been regarded as a debilitated condition, accompanied by nervousness or an occasional twitching of a muscle. The necessity, therefore, of carefully searching for and removing any cause of disease in a neurotic child comes within the prophylactic treatment of chorea.

The medical advice frequently given parents to do nothing, because a child will outgrow a disease or will be cured by changes that take place at puberty, is wrong. It does not, as a rule, if followed, result in the cure of the patient at that age, but either causes an exaggeration of the existing disorder or the development of some other disease more difficult to cure. Chorea is one of those diseases more frequently developed at puberty than at any other age.

Every congenital malformation affects the nervous system of the individual, either by reflex or by depressing mental influence. Peripheral, non-inflammatory irritations, whether of the cutaneous or mucous surfaces, may cause this disease. Preventive treatment requires their correction or removal whenever possible. The removal of *ascaris lumbricoides* from the intestinal tract has been promptly followed by a cessation of choreic symptoms.

At the first manifestation of the disease regular mental work should be discontinued, the child not allowed to attend school, and excitement avoided.

The therapeutic measures employed have been many. Riggs has obtained marked benefit from the use of electricity. He recommends the combined use of the constant current and static electricity.

I have seen rapid improvement by the inhalation of oxygen, nitrogen monoxide, after other measures had been applied without apparent benefit. Drugs must be selected to fit the individual case.

Hyoscyamus, belladonna, gelsemium, arsenicum, cuprum, agaricus, and ignatia are some of the frequently indicated remedies.

SECTIONAL ADDRESS, SECTION OF PEDOL-
OGY.—AMERICAN INSTITUTE OF HOMEOP-
ATHY.

BY

BENJAMIN F. BAILEY, M. D.

DURING the last year or eighteen months the study of pediatrics has seemed to receive a new impetus. For several years prior to that, Keating's work was about the only one issued from the press. In our own school we were absolutely without special literature on the subject. During these few months many books have been issued upon the subject of pediatrics. Among the more important we notice the work of Thomas Morgan Rotch of Harvard Medical School, "Pediatrics." If we omit therapeutics, we may well grade this as a classical work. In our own school we have "Diseases of Children," by C. E. Fisher, M. D., Chicago. This work is evidently the result not only of personal experience, but of a careful compilation and analysis of the literature and published experiences of the profession. It is well written, systematically arranged, and thoroughly adapted to the use of the student and practitioner. "Diseases of Children," by Robert N. Tooker, has, during the same months, been laid upon our desks. It is a most interesting work, from the mind of an independent thinker. I understand we are promised a work upon the same subject by Dr. Martin Deschere of New York City. Burnet of England has given us another of his unique little works, entitled "Delicate and Puny Children," as small as the little ones of which it treats, a babe among books, in that it treats of newly developing ideas; but not by any means puny. One who reads it becomes possessed of new enthusiasm and hope in the

work of building up stronger men and women, to do our work as we shall lay it down. Then last, and probably least, comes the little volume of 300 pages, just issued by the members of your Section of Pedology for this year. This was not written with any idea of asking a special indorsement of the Institute for a special work, but rather for the awakening of our members to the work of conning the field properly covered by this section, and the giving to the profession, as a result of their interest, a *résumé* of the present status of pediatrics. You will miss in this volume all mention of the eye, ear, nose, and throat; partially on account of lack of space, and partially because we believe these subjects belong more properly to the specialist. When the short time to prepare this work is considered, we believe it will be found of much value, although from start to finish, from the setting of the first type to the issuing of the entire edition of 2500 copies, was less than four weeks. It presents itself as a good product of a Western publishing house.

Bulwer says, "Books widen the present by adding to it the past and the future." Bulwer spoke truly, and though a large per cent. of the general practitioners' patients are among the "bairns," it is remarkable how few works upon the diseases of children will be found upon their shelves.

Too many trust to the mysteries of intuition in the study of children's diseases. Intuition is not necromancy, for necromancy, having no basis of origin, is nothing.

Intuition has, as the basis and origin of its luster, early experience and knowledge already obtained. The desirable income attached thereto, and the rapid recognition of the public, have during the last decade developed the surgeon and gynecologist at the expense of our materia medica and our pediatrics.

Let me not be understood as casting slurs. I am a gynecologist myself and thoroughly enthusiastic upon the subject, but to my mind the patching and repairing of bodies

rent by the storms of life is not as far-reaching in its results as the thorough building from the foundations of babyhood, of a building which shall reach out into generations to come, and which may render our children and our children's children better fit to resist the strains of maternity on the one hand, and the shocks of modern business life on the other.

The active physician in his busy life, touched with the health and enthusiasm that seem to be so commonly vouchsafed to the profession, hardly grasps the thought of an Emerson when he tells us that "Life invests itself with inevitable conditions the unwise seek to dodge; which one and another brags that he does not know, brags that they do not touch him; but the brag is on his lips, the conditions are in his soul. If he escape them in one part, they attack him in another more vital part."

Let us, as homeopaths and as physicians, seek the weakened parts of the growing frames of childhood and bind them with the brace and sinews that are, or should be, the outgrowth of a hundred years of homeopathy. I can but concur with Burnet when he says: "Allopathy is at an advanced stage of senile decay, from which there is no recovery." Nothing has in a greater degree hastened its senility and its probable demise than its unwillingness to consider the opinions of any but its own. With the old school, not to believe has been an argument, and a good thing has been condemned solely on account of its ancestry. Let us show ourselves of a more judicial mind and not be too ready to condemn the research of those in other schools of medicine. Pardon the example, but the seed that germinates in the cast-off offal of the alley may, if properly trained and tended, become the noblest tree of the home. So I believe it would be wise if instead of saying, "we do not believe," we should have connected with the American Institute a section for scientific research, composed of candid men in touch with a good bacteriologist, and equipped with a proper experimental laboratory; this section to take up

seriatim the careful examination of the notable discoveries of the year and make report thereon at each meeting of the Institute.

In many cases condemnation of supposed discoveries would surely be the result, and said condemnation would rest upon authentic and properly demonstrated grounds. On the other hand, amid much which might be condemned a kernel of truth might be found which, illumined by the light of Similia, might, like bacillinum, save many a life, while the grosser tuberculinum of Koch can be of use only in diagnosis and in the experimental work of the laboratory. It will not do for us to sit back and calmly say, we as homeopaths do not need these things. It may be true, but neither do we need the mental philosophy of our college days, except as it teaches us, as Hahneman's father taught him, "to think."

The methodical, systematic training necessary in doing research work will make us better students of *materia medica*, which can only be mastered by a methodical and analytical mind.

Further, a year does not pass that we do not have to meet the members of the other school in common combat, and it is most certain that we can better defend our own cause if we are thoroughly acquainted with the grounds upon which our competitors stand.

The great study of the coming decade in pediatrics will be hygiene and prophylactics, and in our remedies we hold the key to the royal secret. Experimental work will teach us when and how to use the key which we hold.

But enough, lest I weary you. In all the year's work among these there has never been evident, on the part of anyone, a thought of self. Untiring zeal, earnest work, and genial, helpful good fellowship have been evident all along the line. May the work that we have tried hard to begin be pushed steadily on to a finish! Remember someone has said, "The fleas would have dragged me out of bed, had they been unanimous." Let us be as powerful as the fleas, and we may yet live to have a greater respect for the work we have ourselves done and to see the "regulars" sacred only in memory.

THE VALUE OF HOMEOPATHIC REMEDIES IN OBSTETRIC PRACTICE.

BY

JULIA CHAPIN-JUMP, M. D.

WHEN engaged in advance to attend a case of labor I take the patient under my special care, advising her as to dress, diet, exercise, and hygienic living in general. No medicine is given unless indicated for her own good or for the welfare of the babe. She is requested to see that the bowels move freely every day, and that the action of the kidneys is normal; otherwise she is to report to me at once. Usually the first malcondition for which we are asked to prescribe is morning sickness. Dietetic treatment will avail much here, and such remedies as *coccus*, *ippecacuanha*, *nux vomica*, and many others may be indicated.

Albuminuria may appear early, in which case *apis*, *cantharis*, or *mercurius corrosivus* will probably correct the trouble.

It is not wise to give routine treatment to every patient before parturition; *macrotin*, *caulophyllum* or *pulsatilla* 3x is not indicated in every case.

In preparing a primipara for labor, no medicine is given unless for some reason it is indicated.

When there is reason to expect a difficult labor the indicated remedy should be carefully selected and given during the last six weeks of gestation. No one remedy is applicable to every case. During labor, if all goes well, no medicine is given.

Sometimes we find the parts dry, and exceedingly sensitive, with little or no dilatation. The woman's face may be flushed, eyes brilliant, and there may be headache. *Belladonna* will be the remedy.

If the patient be irritable, cross, cannot speak a civil word, *chamomilla* will relieve the nervous irritation and make her happy.

When labor has been severe or protracted, and the woman says that she is tired and weak and can do no more, *china* will work like a charm in giving her strength and courage.

Should the pains grow less frequent or weaker ; or if the pains be strong and regular but for a long time no progress is made, give *caulophyllum* in solution every fifteen minutes for one hour, then lengthen the interval. This remedy will work wonders in a severe or protracted labor, and will not injure the babe.

For persistent nausea and vomiting *ipecacuanha* is indicated.

When the pains run from the os upward and seem inefficient, *gelsemium* will relieve.

For a retained placenta *belladonna* or *caulophyllum* may be indicated.

After the completion of labor, unless there are marked indications for some other remedy, *arnica* should always be given.

Belladonna, *caulophyllum*, *coffea*, or *gelsemium* may be needed when the after-pains are severe or long continued. It is better to give only *arnica* for the first six hours.

In case of *post-partum* hemorrhage carefully individualize the case and select the indicated remedy. *China*, *ipecacuanha*, *caulophyllum*, *erigeron*, or *secale* may be needed.

During the period of lactation, should mastitis set in, give *aconite* during the chill. Follow with *bryonia* if the breasts are hard and painful. It will usually cure. Should the breasts be red and sensitive, with red streaks running from the nipple toward the circumference, *belladonna* will be the remedy. If the mammary gland be full of hard, painful nodosities, *phytolacca* will meet the case.

If there be ulceration of the *mammæ* with fistulous openings, *phosphorus* may be the remedy. *Graphites* may be

indicated. Allow me to quote a few cases from my obstetric record, showing the value of pulsatilla. All cases are recorded as soon as dismissed.

CASE IX. Mrs. T. called me at 8 A. M. I found her suffering from general pelvic pains. The long axis of the uterus was transverse, everything out of reach, with dilatation well advanced. At that time my faith in the potency of remedies in labor was very weak and faltering. I waited many hours for nature to correct the position, then gave pulsatilla, but it was too late to effect version, and I had my first shoulder presentation. The right hand came down.

Under chloroform, podalic version was made, and the patient was delivered of a fine boy.

Had pulsatilla been given as a preparatory medicine, or even when I was first called, it might with the help of nature have changed the presentation to a head or a breech.

CASE XIII. Mrs. D. R. B. called me several hours after labor began, as I was near, and the pains were slight and irregular.

On examination I found some dilatation, but the long axis of the uterus was transverse and everything out of reach. I made several calls, and on returning found that no progress had been made. A solution of pulsatilla, 10 drops in half a glassful of water, was prepared, and a teaspoonful given every 15 minutes. Taking a paper, I tried to divert my mind by reading. My anxiety was intense. At the end of an hour an examination showed a change in the direction of the long axis of the uterus. Version had begun. By force of will I compelled myself to wait an hour before making another examination. I then found the vertex presenting, and the labor terminated naturally.

CASE XXV. Mrs. C. M. notified me at 6 P. M. that she had been sick since 6 A. M., but as the pains were not severe, had not thought it necessary to call me. I went to

her at once. On examination found some dilatation, but the long axis of the uterus was transverse. Pulsatilla was given in solution, 10 drops in 10 teaspoonfuls of water; the dose being one teaspoonful every fifteen minutes. At nine o'clock the family and nurse were advised to retire for a little sleep, as they would not be needed till after midnight.

The patient had retired, and a couch in her room was prepared for me.

I gave the pulsatilla every fifteen minutes till eleven o'clock, then advised the patient to try to sleep, and took my couch.

Sleep soon came to me, from which I was wakened about 1 A. M. by a groan from my patient. A terrific pain had seized her, and when I reached her bedside there was a marked change in her form. She told me that the pain had wakened her and that she could feel the child changing its position.

On examination the vertex was found presenting, and at 5 A. M. she was delivered of an eleven-pound boy.

I am convinced that pulsatilla aided nature in each of these cases to make the desired version. In every case where I have given pulsatilla early, the vertex has presented in time.

When, in case of a multipara, I find that the preceding children have suffered from any dyscrasia, remedies are given to correct malconditions and secure a healthy child.

Homeopathic remedies never fail me in correcting abnormal conditions during gestation, parturition, or lying-in.

Adjuvants are used, but they do not come within the province of this paper.

I have yet to lose my first obstetric case, and I attribute my success in a great measure to the use of homeopathic remedies. As the years go by my faith in them is strengthened. I not only believe in their use, I *know* their value.

Since beginning the practice of medicine I have never found it necessary or desirable to go outside of the remedies of our school.

THE CLITORIS.*

BY

M. J. HILL, M. D.

I NEED not give the anatomy of this organ, any more than to hint at its location and structure. I shall compare it to an electric button, and truly this little knot of nerve tissue, situated upon the anterior portion of the female genital fissure, is the electric center of the sexual system of the female.

Thought is but the result of stimulation of nerve filaments, and if the sexual nerves are disturbed at their center or periphery, sexual thoughts will arise and prompt the unfortunate sufferer therefrom to sexual acts.

Nymphomania in its worst form is but the result of undue irritation of sexual nerves, often excited by a pinching clitoral hood or irritating deposits beneath the hood.

I should like to ask how many examine the condition of the clitoris, when examining a lady for pelvic troubles or chronic reflexed troubles?

When we are examining patients for local or constitutional diseases that may be due to irritation of the grand sympathetic nervous system, this nervous central touch should never be overlooked. Some of the best results I have ever obtained for my patients have been by giving attention to this one point, not overlooking other well-known sexual nerve centers.

Treatment.—A pinching clitoral-hood should be liberated by incision, or retraction, or amputation. Deposits beneath the hood must be removed, and parts kept clean, yet not be handled any more than to be kept clean and free from friction. Your own judgment will dictate methods suited to each individual case.

* To be read before Illinois Homeopathic Society at Ottawa, 1896.

Cystic tumors of the clitoris sometimes are curable by evacuating their contents; they may require dissection complete. Fibroid tumors should be removed. Malignant tumors should be treated as malignant growths in other parts of the body.

The great source of evil is from the production of a mental unrest and evil to the morals of the woman; this may be avoided by proper attention given to this organ in childhood and young womanhood.

Could I portray the amount of evil this neglect has caused! Think of the brothels in this land. The young women ruined in society. The thousands of illegitimate children. High hopes and aspirations of many blighted for all times. Homes abandoned. Bleeding and broken hearts everywhere. The result of an act in an unguarded moment often causes a lifetime of sorrow and remorse; an act often repented of but never forgotten. God in his divine will and kindness to his creatures can forgive, while man may blame and condemn the unfortunate. The medical adviser ought to have corrected the trouble by attending to the clitoris in youth. "May we be forgiven for our neglect!" When we neglect our opportunity to do our patient a moral good we are as censurable, yea, more so, than when we neglect her bodily infirmities. I feel that we as a profession have more to do than we have done in this line. While we enter the homes of this land in dire distressing times, let us carry with us the knowledge, and use it for the betterment of the race. To give medicine is one thing for us to do, but to remove the cause of evil in the family is of much greater worth than to be besought to cover up its results in after-time. Although the doctor's fees may not be so great, his reward in his own conscience is greater.

SIX UNUSUAL REMEDIES IN SCARLATINA.

BY

WILLIS YOUNG, M. D.

DURING the writing of the last part of this paper, which was written first, a few thoughts crystallized that induced me to feel much more kindly than heretofore toward the member of the antagonistic school, but still left me somewhat provoked at his refusal to advance, hardly to change, in therapeutic philosophy; for he has not only the privilege but the invitation to investigate a science long since made clear theoretically and proved practically by a huge mass of facts.

He accuses us of being "symptom prescribers," which we are, but not in the sense in which he used the phrase—that is, as prescribers having in view relief from one or a few symptoms. If we will remember that diseases are only made manifest by symptoms, and that many of the symptoms we meet are absolutely unaccountable with the present knowledge of physiology, and equally incapable of interpretation as far as the present knowledge of pathology is concerned, we see at once that we are symptom prescribers, but in the sense that we take into account all symptoms as representing completely the pathological condition to be overcome.

Our method of applying drugs to cover this pathological condition represented by the symptoms has, as the result of experiment confirmed by experience, taught us that the curative operation is embraced within the limits of the physical law of Similia. To the superficial thinker, this law is but a paradoxical rule. The quantity of the drug to be given is likewise only to be proved by experiment, and that the experiment is not yet completed, hear the hot discussion that follows, should anyone be so bold as to publicly raise the potency question.

We are pathological prescribers and ought to be glad of it instead of resenting the term, as many of our school do; and are such because Hahnemann had the genius to recognize a result long before he could understand perfectly the forces producing it. He was in this respect not only far in advance of the age in which he lived, but even ahead of our own, and while we are making practical use of his genius, it is chiefly the old school who, by physiological and pathological experiments, are going some day to complete an unbroken chain of deductive reasoning to prove the correctness of the theory. I wish them speedy success.

With this somewhat lengthy, and I hope not altogether untimely prelude, I will proceed to the subject to which the worthy chairman has, with characteristic assurance, assigned me.

Phytolacca.—I cherish a particular regard for this remedy, for, prescribed by Dr. Allen P. Carr of Rochester, N. Y., whom you all know, it has the doubtful honor of having saved the writer's life from an attack of malignant diphtheria. With the most pacific motives I might mention incidentally that one dose of the C. M. potency accomplished the result. As in diphtheria, so in scarlatina, the throat symptoms are the ones most likely to attract the prescriber's attention.

The tonsils and fauces are much swollen, and are dark, bluish red, and ulcerated, the right side being most affected—the uvula is large and œdematous. This œdema at once suggests apis (not an unusual remedy in scarlatina). The fact that both remedies present albuminuria and suppression of urine may further assist in the confounding.

Differentiation is readily made from the bright redness of the apis throat and the absence of the intense fetor so characteristic of phytolacca. Two other throat symptoms of phytolacca are the extreme sensitiveness of the neck to touch and the aggravation caused by hot drinks—just as in lach., excepting that here the symptoms are left-sided.

Phytolacca presents an acrid, excoriating nasal discharge, suggesting also arsen. and arum t. The tongue is peculiar, and I think characteristic of phytolacca, showing a comparatively clean but dry center, the sides being coated brown. Pulsatilla has dryness of the center of tongue, but it is entirely subjective—I have seen it a number of times.

The eruption of phytolacca is of the miliary variety, the skin is dry and shriveled—feels like brown paper—these symptoms, coupled with great restlessness and rheumatism of the joints; call to mind rhus tox.—but it possesses none of the angina and fetor.

Muriatic Acid.—Fortunately the conditions calling for this remedy are so rare that it is entitled to a place in the “unusual” class; its very prominent characteristic is prostration, present in all the acids as well as in ars., carbo veg., etc.

The cuticle becomes very rapidly covered with a rash intensely red, and is remarkably hot, resembling bell. The patient is either exceedingly anxious and restless, or more likely comatose. Should this last be the case, the eruption will probably come out imperfectly in blotches, and be interspersed with petechiæ—themselves indicative of great prostration. The skin will then be bluish from the weakened heart action, the heart participating prominently in the general prostration, further indicated by the weak and slow pulse which intermits every third beat, as in nat. mur. The skin is likely soon to be the site of very painful blood boils. The throat is intensely sore, dark red or bluish; the mouth lined with dirty aphthous ulcers; the nose discharging thin acrid pus, and the breath disgustingly foul. Respiration, sighing, and groaning; the bladder and rectum empty themselves involuntarily; and to add to the patient's misery, if he be conscious enough to appreciate it, exceedingly painful hemorrhoids accompany the diarrhea. A prominent symptom of this remedy, and one indicating the intense adynamia, is the sliding down in bed.

Zincum.—I am well aware that some authorities deny that meningitis occurs during or forms part of some attacks of scarlatina ; but whether the symptoms indicating the exhibitions of this remedy are due to actual basilar meningitis, or are merely due to hyperæmia, they are severe and unusual. As suggested, the symptoms pointing to cerebral implication are most prominent.

The patient has no power of volition, mental or physical, is unconscious, and utters frequently the *cri encéphalique*. He lies motionless, excepting for the involuntary jerking and twitching of the limbs—especially the lower—or else violent convulsions, alternating with stupor are present. The entire body is bluish, cold, and clammy, excepting the occiput, which is very hot—urine is scant and bloody. These symptoms are often due to non-appearance of the eruption.

Ammonium Carb.—Is indicated in the malignant form of scarlatina. The rash it causes is of the miliary variety—tonsils are dark red and livid, and gangrenous, with, of course, great fetor, and the neck much swollen. These symptoms can be distinguished from the similar conditions of other remedies by the abundant collection of exceedingly shiny and sticky saliva, and the presence of painful vesicles on the tongue. Parotitis, particularly of the right side, accompanied by swelling and induration of the lymphatic glands under the right angle of the jaw. Respiration is difficult and stertorous, is accompanied by a short cough and threatened asphyxia. Urination is involuntary as is defecation, which is accompanied by excessive vomiting.

To have differentiated these remedies from others resembling them would have resulted in greatly extending an already long paper, so I have refrained from attempting it. Finally I must disclaim all originality for that part dealing with symptomatology.

APPLICATION OF THE FORCEPS.*

TRANSLATED BYB. F. UNDERWOOD, M. D.

(Continued from p. 458, September, 1896.)

What remains to be done to complete extraction? The descent of the head is to be completed, rotation provoked, and the head brought through the inferior strait on to the floor of the pelvis and finally outside of the vulva.

EXTRACTION.

(a) Completing the descent. If not already there, the head is to be brought by traction in the axis of the blades, and in the known axis of the pelvis, upon the floor of pelvis. If there, it is to be retained in position upon the entrance of the inferior strait by gentle traction until resistance can be felt and the posterior portion of the perineum has become distended. It has already been explained how this is to be done with the forceps of Levret and the forceps of Tarnier.

(b) Rotation. When, and only when, the descent of the head has been completed and the perineum distended, traction being sustained, a gentle movement of rotation should be imparted to the forceps, if they have not already received it from the movement of the fetus, for the purpose of bringing the nape of the neck under the pubes, the occiput under the symphysis.

It happens, sometimes, that the novice is not able to recall, when the forceps have been applied, which side the occiput is upon which it is necessary to turn. It is to be borne in mind that it is always upon the same side as the pelvic concavity of the forceps, and that the position

* From the French of Professor Farabeuf and Dr. Varnier.

of this, although it may be concealed within the depths of the vagina, is revealed by the pivot, which is always at right angles to the concavity of the blades.

As a result of the rotation, the left blade, the posterior, will come directly to the left ; the right blade, the anterior, will go directly to the right.

Rotation will be complete when the handle of the left blade has passed to the right, the handle of the left blade to the left, the hooks pointing outward.

This movement of rotation of the blades, and consequently of the head which they grasp, is made by giving to the ends of the fingers at the extremity of the handles, a

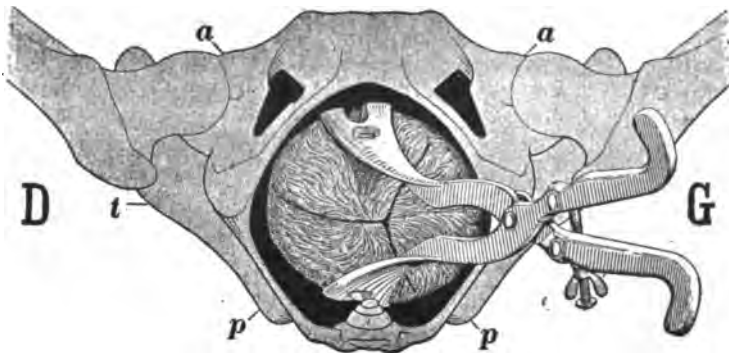


FIG. 41.

circular motion about the longitudinal axis of the head, axis parallel to that of the blades. In the present case—occipital left transverse position—the handles describe an arc of 90° and stop on the median plane in a corresponding position to the occipital pubic position which the head has taken. The illustrations, Figs. 41, 42, and 43, show the successive steps of the evolution.

Fig. 41. Vertex at the inferior strait, occipital left transverse position, the forceps have been applied, articulated, and locked. Rotation has been made to bring the occiput

in front, withdrawing the right branch to the right and advancing the left branch to the left, in twice 45° .

Fig. 42. Vertex at the inferior strait in occipito left

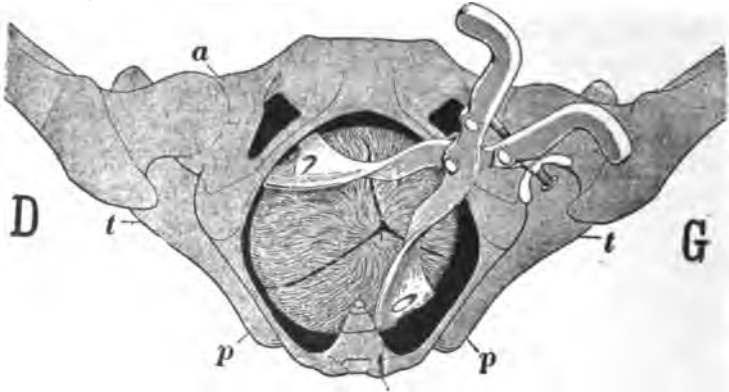


FIG. 42.

anterior position, first step of the rotation given to the head in the initial position, occipital left transverse.

Fig. 43. Vertex at the inferior strait in direct anterior position; second and last stage of the rotation of two movements of 45° undergone by the head from the original position, occipital left transverse.

(c) and (d) Engagement in the soft pelvis and extraction from the vulva.

As in the direct application of the forceps the head is yet to be brought through the soft pelvis by almost horizontal traction and by traction progressively raised through the vulva.

C. Occipital left posterior application.

Vertex in occipital left posterior position. Head flexed.

Practice shows that in the presence of an occipital oblique posterior position which is slow to enter upon rotation, the accoucheur should act as if the head was in the corresponding transverse position, for the reason that the mere introduction of the guiding hand posteriorly in the sacro-sciatic

cavity (the hand which should direct the introduction of the first blade, the posterior) is sufficient in the great majority of cases to drive the occiput to the extremity of the transverse diameter, directly upon the side.

The occipital left posterior position is therefore ordinarily transferred with facility into the left transverse position by the simple introduction of the first guiding hand. This, therefore, will be the practice: counting upon the rotary action of the guiding hand, the introduction of the forceps

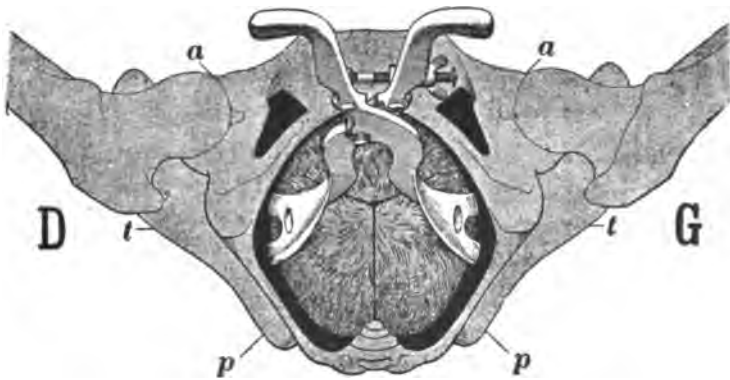


FIG. 43.

will be made as if the position were the left occipital transverse. For the occipital right posterior it will be the right hand which will be introduced flat, directly backward.

Now, as a possible resistance may be supposed, the method of applying the forceps to the head, in an occipital left posterior position, will be according to the classic method, which consists in turning the pelvic concavity of the forceps toward the front, which is, in this case, forward to the right (Fig 44).

The flexed head has descended, more or less deeply, in the pelvis, generally near to the inferior strait; but has not yet engaged; the occiput is posterior and to the left, in the sacro-sciatic space; the forehead anterior and to the right

in the direction of the ilio-pectineal eminence, that is to say, in the right oblique diameter of the pelvis, following which the sagittal suture may be felt. The right oblique diameter is occupied by the sub-occipito-bregmatic diameter, and the left oblique by the biparietal diameter, to which the blades are applied.

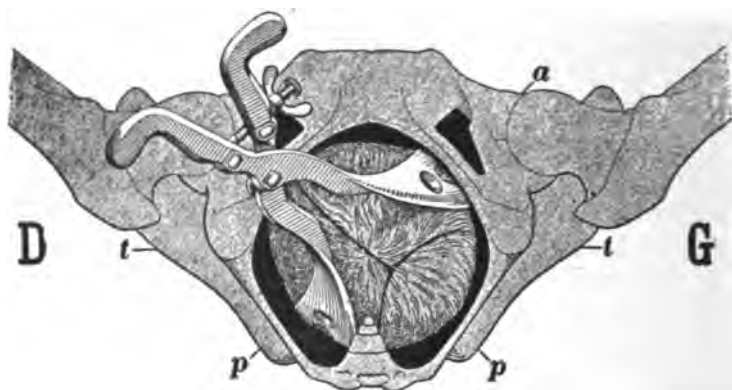


FIG. 44.

Fig. 44. Vertex at the inferior strait in occipital right posterior position, with the forceps properly applied upon the parieto-malar lines, but with the concavity anterior, to the right, the same as the forehead. The right blade being posterior is the one which it is necessary to introduce first. The left will follow, crossing above the one first placed. It will be necessary to uncross them to obtain the position represented: the pivot below, the notch above.

At the posterior extremity of this left oblique diameter, that is to say, to the right between the coccyx and the ischium, there is a large space where the hand may be easily introduced, and the posterior ear (the left) felt, a mark of certainty for the application of the posterior blade. The anterior ear is forward and to the left.

On separating the lips of the vulva, it is the oblique parie-

tal suture at a right angle, forward and to the left, which appears; while the posterior parietal (to which it is necessary to apply the first blade), obliquely turned, is profoundly hidden in the sacro-iliac cavity before which it mounts to the height of the superior strait.

I. In the preceding case the head should be taken in the long diameter and by the sides.

Consequently: the right blade posteriorly; the left blade anteriorly.

II. The forceps should never be introduced in the pelvic cavity toward the anterior arc of the basin.

Consequently: the concavity of the blades will be turned forward and to the right; and the impossible, turning them backward and to the left, like the occiput, must not be attempted.

If we follow the consequences of this new seizure to the moment of executing the rotation which should bring the sagittal suture into the anterior posterior diameter of the pelvis, three steps will present themselves:

1. Step of minor rotation. By a minor rotation of 45° bring the forehead under the symphysis and the occiput directly posterior, which will place the concavity of the forceps in the pelvis for extraction of the fetus in the occipito-sacral position, which procedure has been previously described.

2. Step of major rotation. By a grand rotation, three times 45° , bring the forehead directly posterior and the occiput under the symphysis, which will place the head in position for extraction in the occipito-pubic position, but will bring the forceps wrong side outward; with the concavity to the coccyx.

3. Step of major rotation interrupted by a change of seizure.

The final step is made by forcing the occipital left transverse position, causing the forehead to recede and the occiput to advance 45° . When this transformation has

been made, open the forceps of which the concavity like the forehead looks to the right, and reapply them in the opposite direction, concavity turned toward the left like the occiput [which movement has been previously described]; then the rotation which will bring the head and forceps properly placed in the pelvis for extraction in the occipito-pubic position can be made.

What still remains to be done to terminate extraction? The head is to be taken in its long diameter, by the sides, the concavity of the forceps turned like the forehead, forward and to the right.

Knowing this, the forceps should be held on the outside of the pelvis, in both hands, in the position which they will occupy in the pelvis when the head is properly grasped; the handle of the right blade, the highest, held in the right hand, its blade the lowest, to the right of the mother, and posteriorly, to grasp the posterior parietal; and the handle of the left blade, the lowest, held in the left hand, the blade directed to the left, anteriorly, to go behind the left ilio-pectineal eminence to grasp the anterior parietal (Fig. 44).

Without quitting this position or losing sight of the attitude, these two general rules should be remembered.

First general rule. It is necessary to introduce first the blade which will be posterior, to the end of having all facility for placing it well, for upon its proper placing depends the success of the operation.

It is the right blade in the present case, occipital left posterior.

Second general rule. The blade introduced second can only be introduced above the first, and necessarily its handle crosses over that of the first.

In the present case, occipital left posterior, the blade introduced secondly is the left, the pivoted, which crosses the first, the notched, therefore it does not offer the pivot to the notch of the latter. That articulation may be pos-

sible the handles must be uncrossed and recrossed to bring the notched blade above the pivoted one.

Therefore the right branch, the notched, held in the right hand, will be the first introduced, preceded and guided by the left hand, and it will be at the beginning well placed to the right posteriorly. This done, the left branch, pivoted, intended to come to the left, anteriorly, opposite to the first, will be introduced on the right hand, where it is possible to do so, that is to say, to the left, posteriorly, to the right, even of the occiput.

By a well-known movement of Mme. Lachappalle in twice 45° , it will be brought in its definite position left anterior, passing through the transverse position. At the end this will bring the pivoted blade above that first placed. It will be necessary, therefore, to uncross and recross them to be able to articulate them.

The blades are now separated and laid, oiled upon their convexities only, conveniently at hand, upon a napkin moistened with an antiseptic fluid.

Book Reviews.

All manuscripts for publication, and all books for review, in this journal should be sent to the Publication Office, 133 William Street, New York.

THE CHRONIC DISEASES, THEIR PECULIAR NATURE, AND THEIR HOMEOPATHIC CURE. By DR. SAMUEL HAHNEMANN. Translated from the second enlarged German edition of 1835, by Professor LOUIS H. TAFEL; with annotations by RICHARD HUGHES, M. D. Edited by PEMBERTON DUDLEY, M. D. Philadelphia: Boericke & Tafel, 1896. Pages 600. Half morocco, \$10.00 net.

This imposing volume, a production worthy of the centennial year of homeopathy, is a critical translation of the second enlarged German edition of Hahnemann's "Chronic Diseases," which was issued in 1835. As originally published, "Chronic

Diseases" consisted of five parts, which are collected into one in the present volume, which contains a short preface by Professor Tafel, the translator; a prefatory note to the *Materia Medica* section by Dr. Hughes; a preface by the editor; which are followed by the prefaces written by Hahnemann to the different parts as they were originally published; the preface to the fourth part being an "Inquiry into the Process of Homeopathic Healing," and that to the fifth a consideration of "Dilutions and Potencies (Dynamizations)." The preface to the third part, "Concerning the Technical Part of Homeopathy," which is here made use of as an introduction to the antipsoric medicines, contains Hahnemann's directions for the administration of drugs in acute and chronic cases. The first 150 pages of the book proper contain essays: I, on the "Nature of Chronic Diseases;" II, on "Sycosis;" III, on "Syphilis;" IV, on "Psora," concluding with explicit directions for triturating certain substances up to the point of solubility.

The remainder of the book is devoted to the symptom lists of forty-eight antipsoric medicines, each pathogenesis being preceded by a few paragraphs of historical references, directions for the preparation of the drug, list of antidotes, and therapeutic suggestions. A complete list is given of them as follows: Agaricus, alumina, ammonium carb., ammonium muriaticum, anacardium, antimonium crudum, arsen. alb., aurum, aurum mur., baryta carb., borax venata, calc. carb., carbo an., carbo veg., causticum, clematis erecta, colocynthis, conium, caprum, digitalis purp., dulcamara, euphorbium, graphites, guaiacum, hepar sulph., iodum, kali carb., lycopodium, magnesia carb., magn. mur., manganum, mezereum, muriaticum acidum, nat. carb., nat. mur., nitri. acidum, nitrum, petroleum, phos., phos. acidum, platina, sarsaparilla, sepia, silicea, stannum, sulph., sulph. acidum, zincum.

A translation of the work was made in 1845-46 by Dr. Charles J. Hempel, but was not received with much favor, as it was claimed that the translator was inexact in his methods and had omitted a great many symptoms and the initials of the provers. In the present edition the publishers, in view of these omissions and inaccuracies, have had a new translation made, which competent critics praise as being well done, and, with the annotations

of Professors Hughes and Dudley, have produced a work free from the errors which marked the former edition.

SPECIAL PATHOLOGY AND DIAGNOSIS, WITH THERAPEUTIC HINTS.

By C. G. RAUE, M. D., formerly professor of special pathology and therapeutics in the Hahnemann Medical College of Philadelphia. Fourth edition. Revised and augmented. Philadelphia: Boericke & Tafel, 1896. Pages 1026. Cloth, \$7.00 net; half morocco, \$8.00 net.

Coincident almost with the appearance of the fourth edition of this book, Professor Raue passed on to join his illustrious coworkers. Professors Hering, Thomas, Gause, with whom he was associated at the Hahnemann Medical College when the first edition of "Special Pathology and Therapeutic Hints" appeared—almost a pamphlet beside the present massive volume. In all the years which have gone since the first edition appeared we have never found a work which could take the place of the "Special Pathology and Therapeutic Hints," and have welcomed each new edition, not because it was an improvement, but because it was an addition to a book which in times of doubt and perplexity had proved, over and over again, its value. In this, the fourth edition, there are a number of changes and revisions induced by the progress of medical science since the appearance of the previous edition. A new chapter on mental diseases has been added; the object being to bring to the attention of the general practitioner and student, in a concise manner, the present state of this branch of medicine as developed in later years by practical experience and the progress of psychology. Some changes have also been made in the classification of acute diseases; those of infectious origin being grouped into the chapter, "Acute Infectious Diseases." The book is well printed in small, though clear, type, which permits of compressing a vast amount of matter into a convenient volume, which can be easily consulted, as this book must be.

VETERINARY HOMEOPATHY IN ITS APPLICATION TO THE HORSE; including a code of common suggestive symptoms. By JOHN SUTCLIFFE HUNDALL, member of the Royal College of Veterinary Surgeons, England. Philadelphia: Boericke & Tafel, 1896. Pages 325. Cloth, \$2.00 net.

The object of the author of this work has been to furnish, in clear and concise language, information which will enable those

having charge of horses to discover what ails the animal when signs of illness or incapacity are noticed, and to treat it when ill. As the book is intended for those who have no acquaintance with medicines or disease, the author has treated of the more common and oft-recurring diseases, and has sought to use the terms that will be generally understood by those having charge of horses. With a view of making it comparatively easy to discover the ailment affecting an animal he has prepared a list of suggestive symptoms, indicating the diseases in which these symptoms occur and pointing to the proper treatment. This plan will be found of material help to those not familiar with anatomy or physiology. The work is prepared with marked intelligence, and will prove of great value to every owner of a horse, even though he should not feel called upon to treat it when ill.

A WORK ON HOMEOPATHIC INSTITUTES.—Messrs. Boericke & Runyon, San Francisco, announce the publication, "A Compend of the Principles of Homeopathy," by William Boericke, M. D., professor of materia medica and therapeutics at the Hahnemann Hospital College of San Francisco. Pages 160. Price, bound in cloth, \$1.50. It will cover precisely the whole field of homeopathy, with many references to its literature for the further systematic study of homeopathy, both as a science and as a practical art.

Materia Medica.

Mephitis in Whooping Cough.—Dr. Conzelman.—Cough spasmodic, catarrhal element imperfectly developed; child hoarse, sometimes croupy, spasm of larynx with long-drawn whoop, with little or no expectoration. Child is aroused by sudden contraction of throat, followed by a rapid spasm. Cough causes a smothering sensation, child cannot exhale. Vomit of all food, hours after eating. Face bloated, cough and vomit worse at night and on lying down.

Lilium Tigrinum in Uterine Diseases.—This is one of the

best remedies in slow recovery after confinement or abortion, especially in cases of subinvolution. The class of patients it will help is "cross, cranky women." Some of the symptoms calling for it are pain in left ovary, shooting across to right and down limbs. Weight in pelvis, with feeling that everything would protrude. (In this it resembles sepia.) The leucorrhœa of lilium is yellowish brown, or yellow, and excoriating.

Sulphur in Crusta Lactea.—Dr. Goullon.—A child, who had been quite well up to his ninth month, was brought to me with an eruption on the head, which was at first dry, afterward exuding and spreading all over the forehead and ear, papules excreting a yellow matter. There was much itching. Sulphur 6 did nothing, and I gave about 1 grain of sulphur 1st trit. Four weeks later the parent reported the child doing well, the eruption having declined rapidly, disappearing entirely the second week.

Crocus in Uterine Disorders.—This drug manifests a remarkable affinity for the uterus, where it produces and cures venous congestion resulting in a passive uterine hemorrhage, the blood being dark, clotted, and stringy. The power of crocus as an abortifacient has long been recognized, and homeopathy has shown that its persistent use will remove a tendency to miscarry.

Lobelia in the Treatment of Infantile Colic.—Dr. Holton, Calif. Med. Jour.—On subsequent visits upon obstetrical cases, doctors are often requested to prescribe for the relief of what the nurse calls colic. After ascertaining that the cause of distress is not mechanical, such as pins, chafing of clothing, etc., I put one drop of lobelia tincture in an ounce of water, and give one-half teaspoonful, warm, to the infant. The little one will usually fall asleep in five minutes. Any return of the trouble will yield to one or two doses. I have used this for many years, and never knew it to fail in any case where those conditions were present.

Calcareæ Phos. in Rachitis.—Dr. Arndt.—In delicate children, when caused by soft sponginess of the bones from want of phosphate of lime molecules; skull soft and thin, with crackling noises when pressed upon; delayed closure of the fontanelles; sallow, earthy complexion; face pimpled; retarded dentition; emaciation; swollen condyles in both extremities; spina bifida;

hard bumps on cranium ; cold tremors ; child cannot hold head upright.

Euphrasia in Pertussis.—Dr. Conzelman.—Catarrhal symptom prominent. Suffocating cough, with profuse lachrymation and fluent coryza; the watery mucus is difficult to dislodge and expectoration occurs only in morning. Cough only during daytime, none at night. Cough worse evenings ; when awaking from sleep, from exposure to wind, the secretions are of an acrid watery nature.

Cimicifuga in Uterine Disorders.—Dr. A. C. Cowperthwaite.—This drug, though not resembling belladonna, is the opposite of caulophyllum, its action being due to nerve irritation spasms. It therefore becomes an invaluable remedy for uterine irritation and reflex neuroses resulting therefrom. Hysteria, chorea, neuralgia, etc., resulting from uterine irritation, most often call for cimicifuga. It is second only to pulsatilla in amenorrhœa, especially suppressed menstruation from cold or emotions, rheumatic or neuralgic dysmenorrhea, with shooting pains, weight, and bearing-down feeling in uterine region and small of back. The shooting pains are most apt to go from side to side rather than up and down. Also a valuable post-partum remedy, after-pains, rigid os, etc., due to spasms rather than to congestion. Belladonna is a congestion remedy, caulophyllum an atonic remedy, and cimicifuga a spasmodic remedy.

Bryonia in Ovarian Pains.—Dr. McMichael.—Hahn.—Soreness of right ovary, like a sore spot, which extends into thighs, worse while at rest, stinging, stitching, or shooting pains extending toward the hip, worse on deep inspiration and from touch. Concomitants : Menses too early and too profuse, with dark red blood. Constipation, stools hard and dry. Great irritability. Vertigo on rising. Headache worse from motion, tongue white, excessive thirst, feeling of stone in stomach. Especially adapted to slender persons with nervous and bilious temperaments.

Helonias in Pelvic Disorders.—Helonias is an excellent general nervine tonic, with a special tendency to the bladder, gastrointestinal tract, and pelvic organs. It is of decided value in cystitis, ascites, and in amenorrhœa, dysmenorrhea, and menorrhagia.

Obstetrics.

Care of the Perineum.—Dr. C. T. Hood.—It has been my practice to distend the perineum with my hand, using chloroform and taking two fingers and pressing downward and outward on the perineum, until I could put my fist in without trouble. I have very few cases of lacerated perineum ; not more than two in the last hundred which required any stitches. As to puerperal fever and the antiseptic douche : It was my practice for some years after leaving college to use the antiseptic douche, but for the last few years, after the first sterilized douche, I keep the external parts clean with plain water, unless odor appears. In the last two years I have used no antiseptics excepting 1-100 of chlorine water. I have discarded the curette at full term. Where there is an offensive discharge and signs of sepsis, the intra-uterine douche has proven all that is required. In miscarriage the curette is invaluable, however. The ordinary breast pump is an unclean abomination and a source of trouble. Then sometimes the breasts are emptied by some old woman with a mouthful of rotten teeth ; it is a barbarous practice. As to rigid os, one word : I was told by a physician many years ago that a rectal injection of one part of lobelia to four parts of water would generally relieve the condition. I have tried it, and it works very satisfactorily. The bladder should be emptied before labor.

Lacerated Perineum.—Dr. J. J. Thompson.—I repair a great many lacerated perinei, and when I hear a man tell us that he has lacerations in only about two per cent. of his cases, I begin to think that we do not know much about labor. I believe that, with all precautions, from one-fifth to one-third of all primiparæ are torn during labor, and that those who have such a marvelously low percentage of lacerations to report either do not recognize a laceration when they see one, or else do not look for them. Such a report is absurd, and should not be sanctioned by this body. Shall we admit that we are so careless as this would seem to indicate ? If so, I get a great many cases from other practitioners as

careless as I. If it is carelessness on our part, we should reform ; if it is ignorance on the part of the others, we should inform them.

Perineal Lacerations.—Dr. J. M. Walker.—As to lacerations, I give due credit to those who do not have them. Two physicians may work side by side, and one will have lacerations while the other will not. I have a friend who is always telling me of the severe cases of diphtheria he has, and I know they are genuine. He is seldom without one or two cases of malignant diphtheria, while I get but one or two a year. One man may seem to get most of the hard cases and another man get easier ones.

Ocular Examination.—Dr. F. H. Honberger.—In the first two or three years of my practice I had many lacerations, mostly due to my own carelessness ; I allowed the cases to proceed too rapidly. We should retard progress in most cases and allow distension of the perineum. You will find some patients who seem to have no elasticity of tissue, and in these the perineum will rupture in spite of anything you can do. You will find some physicians who will look at a case which has been torn clear down to the sphincter and say, "It is a small affair and needs no repair." Each case should certainly be given the benefit of an ocular examination, as many of the lacerations do not show on the outside. As to chloroform, I use it at any stage, where the patient or the friends do not object. Give it just before each contraction until ready for delivery. You can control the head better by having the patient under an anæsthetic. Hold the head, and allow it to come slowly.

Preventing Lacerations.—Dr. Trimble Pratt.—In the matter of previous preparation, I have a plan which has added materially to my success. I manipulate the perineum for at least a month previous to confinement with some unctuous material like lanoline, etc. This I use internally and externally. With this precaution and slow delivery we shall be able to prevent many lacerations.

Using Anæsthetics.—Dr. H. W. Champlin.—As a rule, I give chloroform in the second stage only. It is recommended that it be given before and during each pain, but if you will also give a

small amount after the pain, the patient will get a little sleep and be rested for the next pain. As to position after confinement, I always allow the patient to use the commode after labor, and she may sit up in the bed or on a chair for a few moments at a time, being careful to guard against the cold. I do not allow the patient to get up on the ninth day. That is a fallacy which we have to combat. I have her remain in bed for the most of the time for three or four weeks. I have had but little experience with infection. The only case I ever lost was one where the husband contracted gonorrhea from the nurse and infected his wife. I had one case with high fever, where the curette was used to good effect, but it was almost impossible to draw the line between malaria and infection. After the uterus had been cleaned out thoroughly, the fever and sweat would reappear regularly; she finally made a good recovery.

A Good Record.—Dr. L. M. Jones.—I can call to mind 238 cases of labor with only one laceration. You can use the hand to assist dilatation and need no other means, and the progress of the head should be retarded. I have used the lobelia injection in thirty-six cases for rigid os and for hour-glass contraction, with excellent results. For hour-glass contraction a ten per cent. solution in warm water is almost a specific. I use about an ounce at a time, and never have had to give but one injection.

Vinegar as an Antiseptic.—Dr. Boyn.—I do not believe that you can use these strong chemical preparations without doing damage in many cases. I think that cleanliness is the main thing to observe. I have found vinegar to be a very valuable remedy to use in wounds to keep down inflammation. I also use, in some cases, a little carbolic acid. Vinegar antidotes many of the infectious substances, and it can be found any time, any place, and anywhere. It will do the work equally as well as anything else.

Homeopathicity of Mercurius Cor. in Albuminuria.—Dr. G. B. Peck.—I should like to direct attention to the similarity between a case of poisoning with corrosive sublimate and a case of puerperal convulsions. When I sent out my letters of

inquiry on this point a number of years ago, quite to my surprise I found that merc. cor. received the highest number of votes as the remedy most frequently indicated in this disease. Here we have the proving of its homeopathicity. I notice that there are more primiparæ affected than multiparæ. One solution of this is that many of the primiparæ affected do not have any chance to become multiparæ. I am reminded of the case of one of the two ladies whom I have had the honor to confine five times. The first time she was under the preliminary care of a cancer doctor, an eclectic, and would not let me give chloroform. She was unconscious, and did not know what was transpiring. The second time I gave ether and she had successful labor. The third child was born at one o'clock in the morning. I remained until about three, and lay down for a couple of hours. After breakfast I took a visitor to the office of her attending physician, and they told me the doctor had just been summoned, and that the patient was in convulsions. He had commenced giving minute doses of morphine, with belladonna and gelsemium in alternation. I found that the convulsions were preceded by about ten minutes by a pain in the head. By keeping her under morphine for twenty-four hours, until the remedies had a chance to act, she was entirely relieved. The inward cause is a poison in the circulation, a foreign body which has no business there. If you have failed to prevent the formation of that substance—and we all may make mistakes—you are as excusable in giving an anæsthetic or the hydrate of chloral as you are in giving an anæsthetic before a surgical operation; the object to be accomplished is the same in both cases. When this lady was to be confined the fourth time she was in Philadelphia, and Dr. Dudley was her physician. When I was notified of her condition I warned the doctor to look out for convulsions. He found the urine heavily loaded with albumin. He put her on arsenicum 3x, and kept it up persistently. When the time came I went to her and examined the urine. I found not a trace of albumin in it, but continued the arsenicum. There was no sign of convulsions at this confinement, nor has there been at the last confinement. I have great faith in digitalis and hellebore.

Retained Placenta.—Dr. G. W. Bowen.—I have not had a

case of retained placenta in the last fifteen years, or any trouble of that kind ; before that time I frequently met these cases. Fifteen years ago I got through Grauvogel a statement which is certainly correct. China cuts off the flow of blood through the placenta, and you will never meet with a case of retained placenta if you will try it. I give a dose a day, and never have a retained or adherent placenta. I give a dose a day for three days before confinement. I would be afraid of giving china earlier in the pregnancy, for fear of cutting off the blood supply of the placenta. I believe it would produce an abortion, and should not dare give it. Regarding the determination of the day of confinement, there are positive signs at least twenty-four hours before the settling down of the uterus. The woman dates from the last menstruation. Milk in the breasts. Then the patient will have diarrhea twenty-four to forty-eight hours before labor. She will have two or three extra movements of the bowels.

Shoulder Presentation.—Dr. Sheldon Leavitt.—In these cases I should perform version ; the genu-pectoral position is spoken of as favorable. It is a good position and brings to bear the force of gravity. The great obstacle to performing version lies in the firm pressure of the presenting parts at the pelvic brim. They are held there tightly, partly by the force of the contracting uterus, and that is increased by the force of gravity as well. In version we must dislodge the part from the pelvic brim, then change the character of the presenting parts. I believe the Trendelenburg position even better. We may improvise by using an inverted chair on the bed ; bringing the hips of the woman on this inclined plane, to be held there by an assistant. Now the weight of the child is carried away from the pelvic brim. I have used this position in a few cases where it was necessary to perform intra-uterine manipulation, and have found it very satisfactory. The advantage over the knee-chest position lies in the easier manipulation of the abdomen. In the knee-chest position it is pretty difficult to work on the pendulous abdomen. With the woman on her back, with the hips elevated, we may work to far better advantage, and with the same ease as if she were in the horizontal position.

Gynecological Etchings.

The Use of Homeopathic Remedies.—Dr. Bushrod James.—On the point of the application of remedies I would like to ask gynecologists whether they have given up the use of calendula in their cases. In my earlier days it was taught in college that calendula was one of the best applications for all incised wounds, and I used it for years, altogether as a local application, before we used the newer applications. I think we have forgotten some of these remedies which were very useful in these cases. It seems to me that if we find a disposition to the want of peristaltic movement, we should take up our nux or colocynth.

I want to urge the use of the homeopathic remedies a little more persistently rather than the strong applications of the old school, and especially with regard to the use of remedies which open the bowels. Now, several are very irritating and I think injurious in these cases, whereas, if you would use something like sweet oil, olive oil, with a copious enema, I think you would accomplish the object very much better than by using such remedies as turpentine, croton oil, etc.

Carcinoma of the Uterus.—Dr. Wood.—Last year sixty-six per cent. of the cases of carcinoma of the uterus were inoperable, and they were inoperable simply because (and that does not come all from homeopathic sources by any means) the men and women in charge of these cases, instead of making an examination, depended upon a blind symptomatology, which proved disastrous to sixty-six per cent. of the cases. This is a sad commentary. It is food for thought. It means that we have, up to the present time, much to learn, and a great deal to charge our general practitioners with, in the way of diagnosis. I say this in all kindness. The time has come when, with our knowledge of diseases of the pelvic organs, the man or woman who will go on treating a suspicious condition of the uterus, one which suggests malignancy, or will go on relying upon a blind symptomatology, or will proceed in an everlasting

uterine tinkering, of sandwiching in tampons—this is all a good thing in its way—is not treating his patients properly. I am not deprecating conservative treatment, but the relying simply upon a blind symptomatology—that is not only reprehensible, but it will become actionable as well. I do not mean to say that I am an agnostic as far as therapeutics are concerned; I believe in therapeutics. I believe in internal medication. I believe that the homeopathic law of cure is the best, but not the only cure by any means. I believe as homeopathic physicians we have the right to follow all laws of cure, but I believe the homeopathic law of cure is the best that has ever been enunciated; but I do not think that a faith in that law should persist in our treatment of those cases until our patient has passed beyond the operative stage into the incurable stage. I think that is where we have made a mistake, and I do not want you to think because some of us gynecologists have narrow foreheads that we do not believe in therapeutics. There is no place in the world where the homeopathic therapeutics are more applicable than in the diseases of women. We have learned much of these diseases. We operate sometimes when we ought not to operate. We have operated oftener in the past in cases where we ought not to operate than we propose to do in the future. We are not all snatching uteri for the almighty dollar; we are working in good faith, and we ask you to believe us when we make that statement.

Audi alteram partem.—Dr. Allen.—I want to be an honest practitioner of medicine. If a member of my family gets a cancer of the uterus, I don't want a man to get up and say to me, "It is too late now; you have been fooling with homeopathic remedies." I have heard enough of this talk from allopathic surgeons. What I want to know of our gynecologists is how many more patients of cancer of the uterus will be alive in five years on operative measures than would be alive in five or ten years from internal treatment. What is the ratio? When you say that that cancer has got to be cut out or your patient's life is sacrificed, do you tell us the truth? Cancer is not a local disease. One school of pathology says it is, that a local growth undergoes cancerous degeneration. I find it transmissible from generation

to generation. I find it preceded by a uniform state of health which allows the development of the cancerous cachexia. I find that condition of general health amenable to internal remedies in many cases, in a distinct percentage of cases. I find that a cancer is a degenerative growth; that it is transmissible in families with certain constitutional tendencies; and I believe that instead of a growth—a benign growth undergoing cancerous degeneration in otherwise healthy individuals—that a cancer develops only as the result of a constitutional cachexia which is inherent in the individual, and that this predisposing cachexia is amenable to internal treatment.

Now, if I am all wrong, I want to know it. If the surgeon, by removing a growth which is going to be cancerous if allowed to remain, is going to save my patient's life, and if by treating that case by internal remedies I am going to contribute to that patient's death, I want to know it.

Hysterectomy for Cancer.—Dr. Green.—I did my first hysterectomy for cancer of the uterus in 1888. From that time until 1893 I performed seven operations for cancer. The diagnosis in every instance was verified by the microscope. Of those seven cases every one is alive to-day. From the beginning of my professional career up to 1888, the time that I did my first hysterectomy for cancer, I probably treated some fifteen or twenty cases; every single case is to-day in its grave. From the time I commenced to operate for cancer until 1893 I probably saw a dozen other cases that were inoperable; every case is dead. At the time the first case came under my observation I had three come into my office in one week—three cases of cancer of the uterus. Two accepted my proposition to operate, and one rejected it. In six months from the day that woman rejected the operation she was dead. The other two are still living. From 1893 to the present time I have operated in a great many cases of cancer that I knew to be cancer and cases of suspected cancer, and I have not been careful in making a microscopical examination in every instance; but to my personal knowledge there is not a case that has not gone on to complete recovery, and I believe that every one will live out her natural lifetime and die from

other trouble. Of course there are many cases of cancer beyond the hope of recovery that can be benefited by the operation, that can be saved a great deal of suffering and pain ; though the disease may return in some other organ or develop in some other tissue, it will not be connected with that suffering that afflicts every patient that dies from a cancerous disease. There is no disease that I know of that produces such suffering and distress to both the patient and friends as cancer ; and those patients are entitled to surgical attention ; if not cured, it relieves them of the distress. I cannot too strongly emphasize the statement of Dr. Wood in regard to the part that laceration has in producing cancer. I believe, in every case of uterine cancer that I have examined, it could be traced to laceration of the cervix ; and we cannot insist too strongly upon women having those lacerations repaired as a safeguard against the occurrence of this disease.

Rectal Cancer.—Dr. T. F. Allen.—A woman came to me with trouble in her rectum. I felt up the rectum with my finger and I found a hard, irregular nodule, and with her evacuations, which were extremely painful, she was passing blood and a little mucus. I took her to a pretty good specialist in New York. He took me one side. He said : "Your patient is doomed : she has cancer of the rectum," and said that an operation was the only thing that could be done for her. I said, "Will that cure her ?" "Well," he said, "it will give her comfort and prolong her life. It will probably come back ; they generally come back in the liver." So I told this good woman that the doctor thought there was degeneration, and that by having an operation her chances of suffering could be greatly lessened. She had a horror of the knife and said : "Let us try for the summer." I said, "We are losing time, and if you feel by and by that you neglected this matter, I shall feel sorry myself." But she said, "No ; I want you to prescribe for me, and we will wait." I could not say any more and I prescribed for her, studied her case as carefully as I could, and gave her magnesium muriaticum. Magnesium muriaticum had no relation to the scirrhus degeneration of the wall of the rectum, but I gave it on account of the symptoms of distress

in the evacuation of the bowels, on account of the hepatic symptoms. Here was the symptomatology, pure and simple. She began to have easy movements ; she lost the blood and mucus to the passages, and within a year the rectum has become absolutely natural. I showed the case to the specialist and he said : " My God ! what has become of the cancer ? "

Homeopathy and Surgery.—Dr. H. W. Pierson.—I am one of those who would like to defend the principle we have taken as the guide and sheet-anchor of our work ; and I am always one of those who would like to defend those who, through their limited knowledge, have made it necessary for expert men to use mechanical means to undo or remedy the serious results of those who fail to become experts in the knowledge of that which could come to each and every one of us. To-day we have surgeons, to a large degree, simply because those who pretend to believe in homeopathy have failed to make themselves masters of the situation ; have failed to recognize in the manifestations of disease that which should be as plain as ABC. If you will study the cases that come to you (I am speaking of the ordinary physician), if you will study your cases as they should be studied, you will find certain tendencies, certain idiosyncrasies, certain things that would help you to a proper knowledge of the tendency of disease, whatever it may be ; and with this knowledge of these tendencies, you may be able many, many times to arrest the condition before it passes into that necessary state when we must have some palliation, some radical means or what—simply postponing the inevitable result. You know that every man born must die, and you know that the life of each and every individual depends largely upon environment and the other means taken for keeping in close conformity with the laws of nature. The surgeon has his legitimate field, and we are exceedingly fortunate that these surgeons have become such experts that they may undo the unfortunate, sad results of those who are not experts in that department ; and if we can bring this matter, as it properly should be brought, to the attention of our young men and our old men, we will be able to show results that will be in fair compensation of principles that we believe to be strictly true.

Pediatrics.

Prophylaxis of Scarlet Fever.—Dr. T. C. Duncan.—It was in the early days that Hahnemann confronted an epidemic of scarlet fever in all its severity, and proved the value of homeopathy. Perhaps some of you have a copy of the picture of Hahnemann sitting by the bedside of a sick child, entitled “Hahnemann discovering Homeopathy.” I investigated its history, and found that in the early days of his investigations, while looking for the simillimum for the smooth scarlet fever of Sydenham, he decided upon belladonna, and such it has proved to be. We little realize how much belladonna has done as a prophylactic for scarlet fever throughout the world. Hahnemann was right when he said there was an epidemic remedy. We meet different forms of this fever. Now it is the smooth variety of Sydenham, involving the kidneys, and here belladonna seems to meet the requirements. Then there is another, a papular form, almost like measles, the papulæ coming through the surface, and here belladonna is not always the remedy. We have a host of remedies indicated in the after-treatment. I have seen several epidemics of this disease, and can think of nothing with as much satisfaction as providing mothers with belladonna during an epidemic of scarlet fever. I caution them to give it but once or twice a day.

Oils in Scarlet Fever.—Dr. Geo. Royal.—I wish the percentage could be raised as to those who do not use oils of any kind. My experience has taught me that if I begin with oil, and anoint the child thoroughly, I have more renal complications to fight. I believe that the use of oil is responsible for many of the renal complications of this disease.

Sequelæ of Scarlet Fever.—Dr. L. C. Grosvenor.—The sequelæ of scarlet fever are frequently more dangerous and more difficult to treat than the fever itself. The most frequent among them is acute desquamative nephritis. I believe it is possible to escape full three-fourths of these troubles by proper feeding.

My cases have had milk almost exclusively, excepting where they have been given malted milk. Then, too, we find cases of malignant scarlatina, or of scarlatina anginosa, with chills, vomiting, then high temperature, delirium; hot, red skin; the peculiar strawberry tongue, etc., where the remedy seems utterly powerless to bring the temperature down. One case will illustrate: I was called to see a boy of seven years; there was vomiting, violent chill, then violent reaction, temperature 105° and 106° , pulse 140 to 150, with pupils widely dilated. I told myself that we should lose the child, unless we could get that temperature down, so I made up my mind to put him in a pack. I placed two blankets on the couch, and a sheet over them. I dipped a large towel in tepid water, and covered and rolled him in it, doing the same for the arms and legs separately, so that he could move them. He went to sleep, and temperature came down to $103\frac{1}{2}^{\circ}$ in less than three hours. Next morning temperature 101° , and delirium gone. Some people look horrified when I speak of the use of tepid water in scarlet fever, but there is no danger if you allow them to cool slowly. Put in acid or listerine, if you desire; it will do no harm.

Cresoline in Pertussis.—Dr. H. P. Skiles.—I have used the cresoline lamp for some years and, while I do not use it to the exclusion of the homeopathic remedy, I use it as a gas-house, by bringing the gas-house to the patient; I have, as yet, seen no harm from it. I look with alarm upon any case of whooping cough in a child under six months of age. I have recorded one or two deaths from this disease in fourteen years.

No Medicine.—Dr. Robert Walters.—I have treated the various diseases of childhood for twenty years, without medicine. I have never had but one death from diphtheria, and that was where the treatment was not properly followed. I have never had but one case of sequelæ from scarlet fever, and that was the result of gross neglect on the part of the nurse. I rely mainly upon dieting and enemata, and give no food until the patient is ready for it. The grandest absurdity imposed upon the world is making a sick person eat when he does not want to. Give him all the water he wants, and at the end of three days you will see the tongue clean off and he will ask for food. When you put food in the stomach

you draw the blood there and may have a retrocession of the rash. Leave the stomach empty and the circulation free, and you will have better results. For the fever I use the tepid injection. It will bring the fever down two or three degrees in one-half an hour; nothing will do it so effectually. If the patients want lemonade or orangeade, give it to them, but no food, as food, for twenty-four, forty-eight, or seventy-two hours. In diphtheria, if you will put pounded ice on the neck, you will have no need of antitoxin.

Bronchial Complications.—Dr. E. R. Snader.—I have always regarded pertussis as a serious disease and one not to be trifled with. Bronchial complications occur in all instances and frequently travel downward even to the lung itself. If latent tuberculosis be present, it may develop; pneumonia, also, may develop phthisis. In these cases where they are complicated with capillary bronchitis, it is folly to waste time with ordinary medicines; in case of capillary bronchitis, obstruction is written all over the patient. The obstruction is purely mechanical, and if you can bring the diaphragm to your aid by means of electricity, you will unload the burden. I have never used cresoline and know nothing of its value. I especially wish to impress upon you that whooping cough is not a disease to be trifled with, but, with its complications, should be looked after carefully. Do not neglect these cases; you not only lose good cases, but bring the profession into disrepute. As to the Hutchinson treatment, it was quite popular with a number of physicians in Philadelphia. They gave a dose of drosera and two weeks later a dose of carbo veg., and it was supposed to materially ameliorate the whole attack. At least two physicians to-day, in Philadelphia, are kept busy sending out Hutchinson's remedies by mail. Personally I never use them. It is suggested that ambrosia and merc. cor. in alternation may be used to good effect.

Corrosive Sublimate Baths in Eczema.—Dr. Wm. E. Leonard.—I have found a great deal of good and permanent benefit from baths of corrosive sublimate. Those patients with stomachs out of order are not good subjects for medicine. It is perfectly wonderful sometimes to see how these cases, particularly those where skin symptoms predominate, will improve under

a course of baths in weak solution of corrosive sublimate. I use about one-fourth of a tablet to a tub of water. In these cases, where there is a nursing child, it should be weaned. The mother is weak and a syphilitic and the drain is great ; now that we have sterilized milk, and malted milk which closely simulates mother's milk, the child should be weaned early.

Diet in Eczema.—Dr. J. H. Moore.—We should pay attention to the alimentary tract in this disease ; I think it is sometimes due to incorrect diet, particularly in bottle-fed babies. It has been my experience that, where the indicated remedy and local applications have failed, a correction of the diet would wind up the case. There is sometimes too much albumin in the child's diet ; sometimes the mother's milk is too heavy for the child. Pollen water is sometimes beneficial ; it flushes the skin and intestines.

Eczema in Infants.—Dr. W. H. Hanchett.—If there is a disease which taxes the patience of both physician and patient, it is eczema. While lacking the dangers of whooping cough, it is one of the most tedious diseases we meet in practice. In a child three or four months of age, whether you are a Hahnemannian homeopath or not, you may be sure you have a case which will last from six to eighteen months. I have failed in many instances, notwithstanding the most careful prescribing; they have lingered along for may be a year and not recovered until they had finished teething. I have had these cases leave me and go to some of my Hahnemannian brethren, who thought they could prescribe better than I, but they did not get well until after they had finished teething.

Baths in Eczema.—Dr. H. W. Champlin.—One trouble is the daily scrubbing which is given the child. I often have the nurse give only one bath a week. I have had obstinate cases where progress seemed retarded by the free use of soap and water. I called on one case when the baby was getting its bath and the mother told me that a delicate skin formed over the surface, but it washed off. The baths were dropped and the baby very promptly recovered. Soap and water are here in the way of the indicated remedy, but the remedy is all-sufficient where diet and hygiene are favorable. I desire to say a good word for calcaria carb. in these cases.

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